

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file or for a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0995738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1603 Essex Farm Rd.</u>		d. STREET ADDRESS <u>1603 Essex Farm Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>F.</u> Last <u>ACKERMAN</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 1907</u>
9. AGE (in years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Wm. F. Ackerman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Allen Crouse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-05-7150</u>	
17. INFORMANT <u>Mrs. Annie E. Ackerman</u>		Address <u>Riderwood 1603 Essex Farm Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		DATE SIGNED <u>10/31/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto</u>		24a. RECEIVED BY REGISTRAR <u>Nov. 5, 1956</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Walter Gray</u>	

BUREAU V. 3

NOV 2 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. The Registrar permits burial, cremation, or removal. File pages 1 and 2 with the Registrar permit. File pages 3 and 4 with the Registrar permit.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0995938
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE N.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON		c. LENGTH OF STAY IN 1b 1 WK.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 712 MURDOCK RD.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILMINGTON 70 x 3	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA C. M. AINSWORTH		4. DATE OF DEATH Month Day Year OCT. 20 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1910
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWY		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY F. DAHLMER		14. MOTHER'S MAIDEN NAME DEMME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-1475	
17. INFORMANT Mr. Harry Ainsworth - 140 Lake Forest Pkwy.		Address Wilmington, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 30 YRS		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) O B E S I T Y		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/56	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Son - Balto. 17 Md		24a. REC'D BY REGISTRAR DATE Oct. 22, 1956	
		24b. REGISTRAR'S SIGNATURE Malcolm Gray	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature. The form is mostly blank with some faint markings.

RECEIVED
OCT 23 1956
BUREAU V. S.

9987

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9802 Hilltop Drive</i>				d. STREET ADDRESS <i>9802 Hilltop Drive</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mr. Thomas Alder</i>				4. DATE OF DEATH <i>October 30th 1956</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 8, 1864</i>	
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Fireman, B & O R R</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>							
13. FATHER'S NAME <i>John Alder</i>				14. MOTHER'S MAIDEN NAME <i>Mary Turnbull</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mrs. Gertrude Jenkins, 9802 Hilltop Dr.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular renal disease</i> <i>442x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1935</i> to <i>Oct. 30, 1956</i> that I last saw the deceased alive on <i>Sept. 20, 1956</i> , and that death occurred at <i>5:30 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>G. M. Bacon</i> M.D. <i>2810 Taylor Ave</i> PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/2/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR <i>NOV - 1 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	

CERTIFICATE OF DEATH

BUREAU Y. S.

NOV 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed in by the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09960

Reg. Dist. No.

37

9988

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks (rural)</u>		c. LENGTH OF STAY IN 1b <u>12 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks (rural)</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belfast Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Almony</u> First <u>Howard</u> Middle <u>Ellsworth</u> Last <u>Almony</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1882</u>
9. AGE (In years last birthday) <u>73 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Almony</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Lloyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-22-0876</u>	
17. INFORMANT <u>Mrs. Carrie Almony,</u>		Address <u>Sparks, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1956</u> , to <u>Oct. 6, 1956</u> , that I last saw the deceased alive on <u>Oct. 6, 1956</u> , and that death occurred at <u>4:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. <u>Parkeston, Md.</u> DATE SIGNED <u>10/7/56</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-9-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>
22d. LOCATION (City, town, or county) <u>White Hall, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>	
24a. REC'D BY REGISTRAR <u>9 Oct 56</u>		DATE <u>9 Oct 56</u>	
24b. REGISTRAR'S SIGNATURE <u>James J. MacRae</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Henry</i>		DATE OF BIRTH <i>10-11-1884</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
SEX <i>Male</i>		RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>None</i>		MARRIAGE <i>Married</i>		DATE OF MARRIAGE <i>1910</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DATE OF DEATH <i>10-11-1966</i>	
PLACE OF DEATH <i>Home</i>		CITY OF DEATH <i>Baltimore, Md.</i>		STATE OF DEATH <i>Md.</i>	
SIGNATURE OF DECEASED <i>John Henry</i>		SIGNATURE OF WITNESS <i>John Henry</i>		DATE OF SIGNATURE <i>10-11-1966</i>	

BUREAU V. 8

OCT 15 1966

RECEIVED

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A153 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9989 CERTIFICATE OF DEATH

09961

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE LOUISIANA MISSISSIPPI PARRISH OF ORLEANS		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN PIKESVILLE		6 weeks		TOWN NEW ORLEANS		TOWN NEW ORLEANS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 706 SUDBROOK ROAD, 8,				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) RUTH (Middle) DUFFY (Last) BARR				(Month) October (Day) 17 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	WHITE	Widowed	August 26, 1892	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker			---		New Orleans, Louisiana		United States
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Andrew J. Duffy				Lucy B. Duffy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		---		Pikesville, 8, Md David N. Barr, Jr. 706 Sudbrook Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A) CARCINOMATOSIS, extension into lungs						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO Carcinoma of the stomach with metastasis						2 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO ---						2 months	
STATING UNDERLYING CAUSE LAST. (C) ---							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
August 2, 1956		Carcinoma of the stomach with metastasis				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 15, 1956 , to October 17, 1956 , that I last saw the deceased alive on October 17, 1956 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
William T. Trabad		Oct 22, 1956		New Orleans		Louisiana	
23. BURIAL, CREMATION, REMOVAL (Specify)		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Burial		Mary B. Elue		Wm. Berryman & Sons		Riverstown, Md	
DATE 10-19-56							

DEATH CERTIFICATE

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES J. JONES		Male		30		August 23, 1895		New York, N.Y.	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
Student		Typhoid fever		Natural		New York, N.Y.		October 17, 1935	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
OCT 22 1956
BUREAU V. S.

1
This is a true and correct copy of the original as filed in the office of the Registrar of Vital Statistics, State of Massachusetts, on the 17th day of October, 1935.
[Signature]
Registrar of Vital Statistics, State of Massachusetts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9990

CERTIFICATE OF DEATH

099624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 19 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 451 Watty Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT First C. Middle BATTY Last		4. DATE OF DEATH Month October Day 5 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 12, 1891 9. AGE (In years last birthday) yrs. 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Office Building	
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Batty		14. MOTHER'S MAIDEN NAME Besty MN: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. 216-03-8584	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE SIGMOID WITH METASTASIS TO THE LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 16, 1956 , to October 5, 1956 , and that death occurred at 5:37 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald D. Mark		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 10/5/56			
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS Charles R. Law Mortuary, 802-04 Madison Ave.	
24a. REC'D BY REGISTRAR DATE 8 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Garber	

RECEIVED

9991

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 hrs 45 mins			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle C Last BAUBLITZ				4. DATE OF DEATH Month October Day 14 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Adjuster		11. BIRTHPLACE (State or foreign country) Maryland (Carroll Co.)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Baublitz		14. MOTHER'S MAIDEN NAME Alice Eberg		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII	
16. SOCIAL SECURITY NO. 214-14-6093		17. INFORMANT Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 422.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from October 14, 1956 to October 14, 1956 and that death occurred at 8:05 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE C. J. Papastrat M.D.		ADDRESS (Street, city or town, state) Veterans Administration Hospital		DATE SIGNED 10/15/56		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 10-18-56		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chmowetz Jr. ADDRESS Chmowetz Funeral Home 3615 Chestnut Ave., Balto	
24a. REC'D BY REGISTRAR DATE 17 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Garber		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9992

CERTIFICATE OF DEATH

09964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.			
				d. STREET ADDRESS 1400 Railroad Ave			
3. NAME OF DECEASED (Type or print) First William Middle Walter Last Bell				4. DATE OF DEATH Month October Day 10 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10b. KIND OF BUSINESS OR INDUSTRY Fire Extinguisher Md		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME John F. Bell				14. MOTHER'S MAIDEN NAME Laura Phillips.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Maggie Bell. 1400 Railroad Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary thrombosis DUE TO (c) arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October 10, 1956 to October 10, 1956 , that I last saw the deceased alive on October 10, 1956 , and that death occurred at 3:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) M.D. 1202 Woodrow Wilson Ave Lutherville, Md.			
PHYSICIAN'S NAME (Type) Dr. [Name]				DATE SIGNED Oct 11, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 13/56		22c. NAME OF CEMETERY OR CREMATORY Saters		22d. LOCATION (City, town, or county) (State) Balto Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan				ADDRESS 3818 Pland Ave		24a. REC'D BY REGISTRAR 15 1956	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

BUREAU V. S.

9561 51 100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09965

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>37 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>61 AVALON AVE</u>				d. STREET ADDRESS <u>61 AVALON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>A.</u> Last <u>BENSON</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 30-1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHECKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIP YARD</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>BENSON</u>				14. MOTHER'S MAIDEN NAME <u>ANNE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-076007</u>		17. INFORMANT Address <u>3541 MERIDIAN</u> <u>MRS HAZEL BENSON INDIANAPOLIS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 9 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OLGATE LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME 2112 DUNDALK</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>10 1956</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. Your files should be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

OCT 10 1956

RECEIVED
OCT 10 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09966

9993

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putty Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putty Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10041 Harford Rd.</u>				d. STREET ADDRESS <u>10041 Harford Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Johanna</u> Middle <u>D.</u> Last <u>Blacklock</u>				4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Gerke</u>				14. MOTHER'S MAIDEN NAME <u>Louise Cruse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Josiah A. Blacklock 1600 Walterswood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sclerosis Coronary</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>For about 2 years</u> , 19 <u>54</u> , to <u>1956</u> , that I last saw the deceased alive on <u>Oct. 22</u> , 19 <u>56</u> , and that death occurred on <u>Oct. 22</u> , 19 <u>56</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Rardin</u> M.D.				ADDRESS (Street, city or town, state) <u>5901 Ayleshire Road Baltimore 12, Md.</u>		DATE SIGNED <u>Oct 25 1956</u>	
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 24, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Chapel</u>		22d. LOCATION (City, town, or county) <u>Balto. Co. Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>Jr. A. M. Bacon</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 25 1956

RECEIVED

9994

CERTIFICATE OF DEATH

Reg. Dist. No.

34

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6424 Liberty Road</u>		d. STREET ADDRESS <u>6424 Liberty Road</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> <u>BLASS</u>		4. DATE OF DEATH Month <u>10-</u> Day <u>13-</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Bashera</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>163X</u>	
17. INFORMANT <u>Sarah Blass - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>163X</u> DUE TO (c) <u>163X</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 Apr</u> , 19 <u>54</u> , to <u>13 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 Oct</u> , 19 <u>56</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. Ann D. Van</u>		ADDRESS (Street, city or town, state) <u>3601 Patuxent Ave</u>	
PHYSICIAN'S NAME (Type) <u>Baltimore 7, Md</u>		DATE SIGNED <u>10/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-15-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON Rd</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc-2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>61956</u>	
ADDRESS <u>2100 Eutaw Place</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIED		SINGLE	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		CITY OF BALTIMORE	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09968

9995 CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

1. **1** **24 hours** after death. The law requires that the death certificate be executed within 24 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

2. **72 hours** after death. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

3. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

4. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

5. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

6. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

7. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

8. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

9. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

10. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

11. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

12. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

13. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

14. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

15. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

16. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

17. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

18. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

19. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

20. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

21. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

22. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

23. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

24. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

25. **Funeral Director** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Holmehurst Ave.</u>		STREET ADDRESS (If rural give location) <u>16 Holmehurst Ave.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Herbert</u> (Middle) <u>B.</u> (Last) <u>Bohanan</u>		(Month) <u>Oct.</u> (Day) <u>2</u> (Year) <u>1950</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>April 7, 1879</u>
9. AGE last birthday <u>77</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prop. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles M. Bohanan</u>		14. MOTHER'S MAIDEN NAME <u>Laura Pursel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Rev. T.M. Bohanan 16 Holmehurst</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-Vascular Renal Disease</u>		<u>7 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Emphysema</u>		<u>6 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8:18</u> , 19 <u>49</u> , to <u>10:2</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>50</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>George E. Kistner</u>		ADDRESS (Street, city, town, state) <u>805 2nd Ave. Balto. Md.</u>	
DATE SIGNED <u>10.2.50</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-5-50</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>OCT 9 1950</u>		REGISTRAR'S SIGNATURE <u>J. E. Barry</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Funeral Home - Catonsville Md.</u>		ADDRESS	

VS AISC 1-55 10M

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

44

9996

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 127 Fleming Drive			
3. NAME OF DECEASED (Type or print) BERNARD C BOOKER				4. DATE OF DEATH October 14 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/23	9. AGE (In years lost birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Sparrows Point, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry Whitley Booker			
14. MOTHER'S MAIDEN NAME Theresa Booker				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II			
16. SOCIAL SECURITY NO. 220 14 1122				17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT HYPERTENSION 445X DUE TO NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from October 6, 1956 , to October 14, 1956 , that I last saw the deceased alive , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C.M. Snyder M.D.				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland			
DATE SIGNED 10/14/56				22. PHYSICIAN'S NAME (Type) C.M. SNYDER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/18/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Maryland				22e. (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802-04 Madison Ave. Baltimore, Md.		24a. REC'D BY REGISTRAR OCT 16 1956	
24b. REGISTRAR'S SIGNATURE Dawson L. Farley				24c. _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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For the purpose of this study, the following hypotheses were formulated:

173

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BUREAU V. 5

1956 16 OCT

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9997

CERTIFICATE OF DEATH

09970

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robb Nursing Home				d. STREET ADDRESS 4015 Villa Nova Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELIA D. BORNMAN				4. DATE OF DEATH Month Day Year 10 6 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/1869	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Hooper				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Virginia Warnsmann-4015 Villa Nova Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451x GASTRIC EXTENSIVE HEMORRHAGE DUE TO (b) _____ DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized							INTERVAL BETWEEN ONSET AND DEATH 24 hrs 7
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from fall , 19 50 , to Oct 6 , 19 56 , that I last saw the deceased alive on Oct 5 , 19 56 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis Dickman				ADDRESS (Street, city or town, state) Pikesville Md			
DATE SIGNED 10/8/56							
PHYSICIAN'S NAME (Type) Louis DALMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		22d. LOCATION (City, town, or county) (State) My Lady's Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Tiedner & Sons - North Pa Ave Baltimore - 13, Md.				24a. REC'D BY REGISTRAR DATE 10/8 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 8

OCT 9 1956

RECEIVED

1. PLACE OF DEATH		2. DATE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK	
17. SIGNATURE OF NOTARY		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF CHIEF OF POLICE		20. SIGNATURE OF SHERIFF	
21. SIGNATURE OF TOWNSHIP CLERK		22. SIGNATURE OF COUNTY CLERK	
23. SIGNATURE OF STATE CLERK		24. SIGNATURE OF FEDERAL CLERK	
25. SIGNATURE OF POSTAL CLERK		26. SIGNATURE OF TELEPHONE CLERK	
27. SIGNATURE OF RAILROAD CLERK		28. SIGNATURE OF AIRLINE CLERK	
29. SIGNATURE OF MARINE CLERK		30. SIGNATURE OF NAVY CLERK	
31. SIGNATURE OF ARMY CLERK		32. SIGNATURE OF AIR FORCE CLERK	
33. SIGNATURE OF SPACE CLERK		34. SIGNATURE OF OTHER CLERK	

09971

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN lb <u>transient</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Putty Hill Rd.</u>		d. STREET ADDRESS <u>XXXXXX Sparks</u> Phoenix	
3. NAME OF DECEASED (Type or print) <u>COURTNEY Oliver Bowman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1904</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metropolitan Dis. Balto. County</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. T. Bowman</u>		14. MOTHER'S MAIDEN NAME <u>? Lawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-16-1879</u>	
17. INFORMANT <u>Ada W. Bowman</u>		Address <u>Phoenix, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Advanced Generalized Arteriosclerosis</u> DUE TO (c) <u>undet.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John C. Hyle</u>		DATE SIGNED <u>10-10-56</u>	
EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-13-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		24a. REC'D BY REGISTRAR DATE <u>10/13/56</u>	
ADDRESS <u>Sparks, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Bacon</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

BUREAU V. S.

OCT 16 1956

RECEIVED

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INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

09972

32

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stevenson</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stevenson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Julie</u>				STREET ADDRESS (If rural give location) <u>Villa Julie Valley Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sister Paulina (Elizabeth Brady)</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 15 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 12, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Brady</u>				14. MOTHER'S MAIDEN NAME <u>Bebiana Vale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS <u>Sister Marie Dolores Villa Julie</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4221 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiac vascular disease</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Oct 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 14</u> , 19 <u>56</u> , and that death occurred at <u>12:10</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Harold H Burns</u>				DATE SIGNED <u>10-16-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>10-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem.</u>	
24. REC'D BY REGISTRAR <u>Oct 17 1956</u>				REGISTRAR'S SIGNATURE <u>Dorothy Newells</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home, Catonsville, Md.</u>	
				LOCATION (City, town, or county) <u>Ilchester</u>		(State) <u>Md.</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Green Spring Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Green Spring Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>BROWN JR</u> Middle <u>LAST</u> Last				4. DATE OF DEATH <u>Oct</u> Month <u>7</u> Day <u>1956</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-5-1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Brown</u>				14. MOTHER'S MAIDEN NAME <u>Frances Hinchester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Gary Black Stevenson md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Liver</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>Oct 7 1956</u> that I last saw the deceased alive on <u>Oct 7 1956</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1101 St Paul St</u> DATE SIGNED <u>Walter A Baetjer</u>							
ACTUAL SIGNATURE <u>Walter A Baetjer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>WALTER A BAETJER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Jenkins</u> ADDRESS <u>4905 York Rd</u>				24a. REC'D BY REGISTRAR <u>DATE 8 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL PUBLIC: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 5

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RECEIVED

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Page One of Two

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>		<p>9. MANNER OF DEATH [REDACTED]</p>	
<p>10. DATE OF DEATH [REDACTED]</p>		<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>15. SIGNATURE OF CORONER [REDACTED]</p>	
<p>16. SIGNATURE OF JUDGE [REDACTED]</p>		<p>17. SIGNATURE OF CLERK [REDACTED]</p>		<p>18. SIGNATURE OF REGISTRAR [REDACTED]</p>	

BUREAU V. S.

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG205 10-26-56 et

1 0002

CERTIFICATE OF DEATH

09975

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> <u>7920 Bridge Ave.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesaco Pk.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>7920 Bride. Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Bubczyk</u> Middle <u>Bubczyk</u> Last				4. DATE OF DEATH Month <u>Oct.</u> Day <u>17,</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>17,</u> Days <u>1956</u>		IF UNDER 24 HRS. Hours <u>1956</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>G. Bubczyk</u>				14. MOTHER'S MAIDEN NAME <u>Maryx Bubczykxxxwife</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mary Bubczyk Wife</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Miliary tuberculosis</u> <u>602x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis</u> DUE TO (c) <u>10 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 1952</u> 19 <u>Oct.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 17,</u> 19 <u>56</u> , and that death occurred at <u>10:15p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Mason M.D.</u>				ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd.</u>			
DATE SIGNED <u>10-18-56</u>							
PHYSICIAN'S NAME (Type) <u>James R. Mason, M. D.</u>				<u>Baltimore 6. Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozazewski</u>				ADDRESS <u>1930 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct. 17, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Edith Hurley</u>							

BUREAU V. 5

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09976

19003

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 14 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 2215 PULASKI STREET			
3. NAME OF DECEASED (Type or print) First CORNELL Middle J. Last BULLOCK				4. DATE OF DEATH Month OCTOBER Day 21 Year 1956			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-09		9. AGE (In years last birthday) yrs. 47	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MESSENGER		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) NORFOLK, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS BULLOCK				14. MOTHER'S MAIDEN NAME LUCEY HENDERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 445X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MALIGNANT HYPERTENSION DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 6 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARALYTIC ILEUS - Duration, 6 Days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 7, 1956 , to Oct. 21, 1956 , and that death occurred at 3:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Armen Bobosian				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 10-21-56	
PHYSICIAN'S NAME (Type) ARMEN BOBOSIAN				M.D. VAH, FORT HOWARD, Maryland 10-21-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-24-56		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. Md.				24a. REC'D BY REGISTRAR Oct 25 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Harber	

10004

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN North Point Village		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Point Village X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7922 St. Clare Lane				STREET ADDRESS (If rural give location) 7922 St. Clare Lane			
3. NAME OF DECEASED: (First) MARY (Middle) SOPHIA (Last) CARLIN				4. DATE (Month) (Day) (Year) OF DEATH: Oct. 29, 19 56.			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH: Nov. 18, 1885	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10B. KIND OF BUSINESS OR INDUSTRY: At Home		11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Adam Hock				14. MOTHER'S MAIDEN NAME: Margaret Schindhelm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: James A. Carlin Same			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.0							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Congestive Heart Failure							14 days.
DUE TO							
(B) Arteriosclerotic Heart Dis.							?10 years.
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from Jan 1, 1956 , to Oct 30, 1956 , that I last saw the deceased alive on Oct 29, 1956 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.							
SIGNATURE [Signature]		ADDRESS M.D. 520 DSt. S.P. 12		DATE SIGNED 10/31/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11-2-56		NAME OF CEMETERY OR CREMATORY SACRED HEART CEM		LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.	
DATE REC'D BY LOCAL REGISTRAR 11-1-56		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR 901 S. CONNELL ST. BALTO., MD.			

MARGIN RESERVED FOR BINDING

VS. A15-10-5

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

520 D ST.

ROGER WINDSOR

CERTIFICATE OF DEATH

10005

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 103 Warren Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle J. Last CHAMBERS		4. DATE OF DEATH Month October Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1892
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles C. Chambers	
14. MOTHER'S MAIDEN NAME Bridgett MN: Stapleton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 217-05-4941		17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH AORTIC STENOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 23, 1956 , to October 24, 1956 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort Howard, Maryland DATE SIGNED 10/25/56			
ACTUAL SIGNATURE C. J. Papastrat M.D. PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-29-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS 6009 Harford Rd., Balto. 14, Md		24a. REC'D BY REGISTRAR 10/30/56 24b. REGISTRAR'S SIGNATURE Burson & Farber	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09979

10006

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 101 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle W. Last CHANEY				4. DATE OF DEATH Month October Day 22 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 4, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree Trimmer Laborer				10b. KIND OF BUSINESS OR INDUSTRY Tree Trimmer		11. BIRTHPLACE (State or foreign country) Savage, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Chaney				14. MOTHER'S MAIDEN NAME Frances Tucker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I				16. SOCIAL SECURITY NO. 220-01-2640		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Mdd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 1956 , to October 22, 1956 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. YAH, FORT HOWARD, MARYLAND 10/23/56							
ACTUAL SIGNATURE C. J. Papastrat M.D. PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. ADDRESS 6009 Harford Road Baltimore 14, Md.				24a. REC'D BY REGISTRAR DATE 30 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
John Doe		45		Male		White		Roman Catholic		Married		High School		Teacher		1234 Main St.		1234 Main St.		October 15, 1955		10:30 AM		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	
John Doe		45		Male		White		Roman Catholic		Married		High School		Teacher		1234 Main St.		1234 Main St.		October 15, 1955		10:30 AM		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

OCT 30 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09980

10007

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 3312 Chestnut Avenue			
3. NAME OF DECEASED (Type or print) JEROME		First E		Middle CHARTERS		Last	
4. DATE OF DEATH Month October		Day 15		Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/96	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sylvester Charters		14. MOTHER'S MAIDEN NAME Lena Fludung			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 216-09-8418		17. INFORMANT Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, LEFT MIDDLE CEREBRAL ARTERY 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 12, 1956 , to October 15, 1956 , that I last saw the deceased alive on October 15, 1956 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. J. Papastrat M.D.				M.D. Veterans Administration Hospital DATE SIGNED 10/16/56			
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.				Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace E. Burgee, Jr.				ADDRESS 3631 Falls Rd., Balto., Md.		24a. REC'D BY REGISTRAR DATE Oct. 17, 1956	
				24b. REGISTRAR'S SIGNATURE Dawson L. Larkay			

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09981

CERTIFICATE OF DEATH

Reg. Dist. No. 37

10008

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>COCKEYSVILLE</u> LENGTH OF STAY (in this place) <u>19 YEARS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>✓</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> 3Y01-4 STREET ADDRESS (If rural give location) <u>2502 N. CALVERT ST.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GERTRAUDE MAY CLARKE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 9 1956</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>10/20/1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>			
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>							
13. FATHER'S NAME <u>THEODORE MONTGOMERY</u>			14. MOTHER'S MAIDEN NAME <u>HARRIET DUBOSS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S ADDRESS <u>Paul L. Smith, Jr. Cockeysville, Md.</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1 IMMEDIATE CAUSE (A) Arterio-Sclerotic Cardio</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Vascular disease</u> (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/7</u> , 19 <u>50</u> , to <u>10/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/9</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Walter J. Kus</u> M.D. <u>Cockeysville Md.</u> DATE SIGNED <u>10/9/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>10-11-56</u>	NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		LOCATION (City, town, or county) (State) <u>BALTO MD</u>			
24. REC'D BY REGISTRAR DATE <u>OCT 11 1956</u>	REGISTRAR'S SIGNATURE <u>Frank Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook</u>		ADDRESS <u>1417 St. Paul St</u>			

RECEIVED

NOTED FOR INFORMATION
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-11-1956 BY 1043 JRS/ML

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FILE NO. 111

1. DECEASED PERSON'S NAME

0008

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE

11. DATE

12. TIME

13. SIGNATURE

14. DATE

15. TIME

16. SIGNATURE

17. DATE

18. TIME

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166. SIGNATURE

167. DATE

BUREAU Y. 8

OCT 11 1956

RECEIVED

10009 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809982
CERTIFICATE OF DEATH

Reg. Dist. No. *12*

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>			c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>726 Howard Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Myrtle Lee Cohee</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1875</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel K. Gootee</u>				14. MOTHER'S MAIDEN NAME <u>Anna R. Griffith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Pikesville</u> <u>Mrs. Louise Draper, 726 Howard Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Breast</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1951</u> , to <u>October 24, 1956</u> , that I last saw the deceased alive on <u>October 24, 1956</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd. Pikesville, Md.</u> DATE SIGNED <u>10/25/56</u>							
ACTUAL SIGNATURE <u>James A. Miller M.D.</u>				PHYSICIAN'S NAME (Type) <u>James A. Miller M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Caroline County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vogel</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>10/27/56</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

BUREAU V. S.

OCT 29 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09983

10010

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 66 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1413 Lemmon Street			
3. NAME OF DECEASED (Type or print) WILLIAM H. COOK				4. DATE OF DEATH October 14 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/5/97	
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seed Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jerry Cook			
14. MOTHER'S MAIDEN NAME Hester Scipio				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I			
16. SOCIAL SECURITY NO. 217 03 9983				17. INFORMANT Clin.Rec.Vet.Adm.Hosp., Ft.Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF LEFT LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that VA attended the deceased from August 9 , 19 56 , to October 14 , 19 56 , that I last saw the deceased alive on October 14 , 19 56 , and that death occurred 11:40A M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland				DATE SIGNED 10/14/56			
ACTUAL SIGNATURE C.M. Snyder M.D.				PHYSICIAN'S NAME (Type) C.M. SNYDER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 17 1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Maryland				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Katie Williams				ADDRESS 322 N. Schroeder St.		24a. REC'D BY REGISTRAR 17 1956	
24b. REGISTRAR'S SIGNATURE James L. Farber				24c. REGISTRAR'S NAME James L. Farber			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Pages 1 and 2 should be filled with the information requested. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the registrar. The registrar will file the certificate and the burial-transit permit.

10011

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	LENGTH OF STAY (In this place) <u>5 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>125 Slade</u>		STREET ADDRESS (If rural give location) <u>125 Slade Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Bertha Schaefer Cox</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct 4</u> 19 <u>56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 14 1876</u>
9. AGE last birthday: <u>80 yrs</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Schaefer</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Maisel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr J W Cox, 125 Slade Ave, Pikesville</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>			<u>2 yrs.</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>56</u> to <u>4 Oct</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3 Oct</u> , 19 <u>56</u> and that death occurred at <u>10</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Paul H Royse</u>		DATE SIGNED <u>4 Oct 56</u>	
ADDRESS <u>Pikesville 8 Md</u>			
M. D. <u>Pikesville 8 Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-6-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Graceland Ridge</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-4-56</u>		REGISTRAR'S SIGNATURE <u>L</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikesville, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-56

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FORWARDED TO THE

RECEIVED

NOV 1964

NOV 1964

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be filled in. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09985

10012

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Aintree Rd.				d. STREET ADDRESS 8 Aintree Rd.			
3. NAME OF DECEASED (Type or print) First LAMBERT Middle FOSTER Last CROMWELL				4. DATE OF DEATH Month Oct. Day 29 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1880		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Engineer - Rtd		10b. KIND OF BUSINESS OR INDUSTRY C. & P. Tel. Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lambert Cromwell				14. MOTHER'S MAIDEN NAME Laura Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Winifred Cromwell - 8 Aintree Rd., Towson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cornary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 36 to 29 Oct , 19 56 , that I last saw the deceased alive on 29 Oct , 19 56 , and that death occurred at 5 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Kiser M.D.				ADDRESS (Street, city or town, state) 6701 York Rd. Baltimore, Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED Nov 5 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schuler & Sons - Balt. 17, Md.				24a. RECEIVED BY REGISTRAR Nov 1, 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MARYLAND STATE DEPARTMENT OF HEALTH

09986

2411 N. Charles Street, Baltimore

9972

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk, Md.</u> LENGTH OF STAY (in this place) <u>23 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>209 Center Street</u>		STREET ADDRESS (If rural give location) <u>209 Center Street</u>	
3. NAME OF DECEASED (Type or Print) <u>LOUIS</u>	(First) <u>LOUIS</u>	(Middle)	(Last) <u>Crosby</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	4. DATE OF DEATH <u>October 13, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver for Railroad Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	8. DATE OF BIRTH <u>March 10, 1911</u>	9. AGE last birthday <u>45</u> yrs. <u>7</u> months <u>3</u> days <u>1</u> hour <u>10</u> min.
11. FATHER'S NAME <u>JIM Crosby</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. BIRTHPLACE (State or foreign country) <u>Chester, South Carolina</u>	14. MOTHER'S MAIDEN NAME <u>Mary Hill</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>705-10-9516</u>	17. INFORMANT <u>NETTA Crosby</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

196X Immediate cause (a) Broncho-pneumonia

Antecedent cause(s) (b) Carcinoma of Spine (L-5)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

2 days7 months11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY	m.			

22. I hereby certify that I attended the deceased from July 10, 1956, to October 13, 1956, that I last saw the deceasedalive on October 13, 1956, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

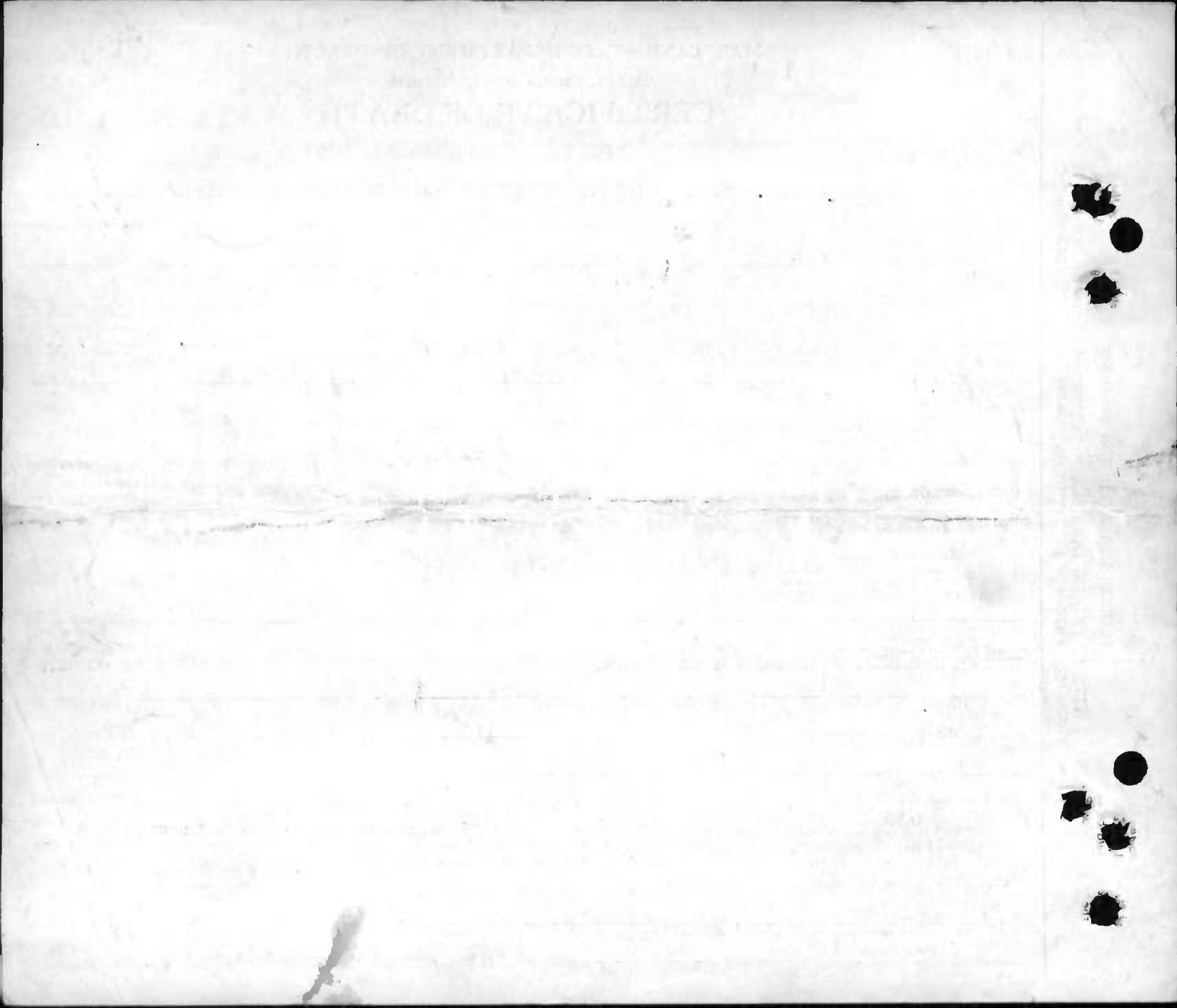
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>Oct 17, 1956</u>	<u>Piney Grove Cem.</u>	<u>Chester, S. C.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Oct. 17, 1956</u>	<u>A. H. Hedrick</u>	<u>Mrs. Frank T. Elickson</u>	<u>1129th Cedar St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09987

10013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ODonnell Hgts</u>				c. LENGTH OF STAY IN 1b <u>20 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6100 Shipview Ave</u>				d. STREET ADDRESS <u>6100 Shipview Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>F.</u> Last <u>Crouse</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1897</u>		9. AGE (In years last birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Simmons</u>				14. MOTHER'S MAIDEN NAME <u>Ida</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John H. Crouse, 6100 Shipview Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO (c) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>800 N. Patterson Park Ave.</u>	
20f. (City or town) <u>Balto. Co.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 1, 1953</u> , to <u>Oct. 16, 1956</u> , that I last saw the deceased alive on <u>Oct. 16, 1956</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. F. Frederick Ruzicka</u>				DATE SIGNED <u>Oct 22 1956</u>			
PHYSICIAN'S NAME (Type) <u>Dr. F. Frederick Ruzicka</u>				ADDRESS (Street, city or town, state) <u>800 N. Patterson Park Ave.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>				ADDRESS <u>4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>Oct 22 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED	

10014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave				d. STREET ADDRESS 508 Lafayette Ave			
3. NAME OF DECEASED (Type or print) First Margaret Middle E. Last Cupero				4. DATE OF DEATH Month Oct. Day 23 Year 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1880	9. AGE (In years lost birth day) 76 yrs.	IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles J. Hachtel				14. MOTHER'S MAIDEN NAME Emma Kull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 422.1		17. INFORMANT Mrs. Garland Milburn, 151 E. Palisade Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Parkinson's syndrome DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1946 , to October 23, 1956 , that I last saw the deceased alive on October 23, 1956 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 10/25/56							
ACTUAL SIGNATURE George A. Knipp, M. D.				M.D. 4116 Edmondson Avenue			
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.				George A. Knipp, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 25/56		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witte				ADDRESS 101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE Oct 25 1956	
				24b. REGISTRAR'S SIGNATURE T. E. Harris			

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CO.	
b. CITY OR TOWN (If outside corporate limits, write name of city or town) CATONSVILLE		c. LENGTH OF STAY IN 1b 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 7
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2601 POPULAR DRIVE	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL First Middle DARRAH Last		4. DATE OF DEATH OCTOBER 13 1956 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-70
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY COAL STOVE CO.	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID DARRAH		14. MOTHER'S MAIDEN NAME MARGARET BUSH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 489-16-7822	
17. INFORMANT Charts SPRING GROVE STATE HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary and generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral nephrolithiasis			INTERVAL BETWEEN ONSET AND DEATH 3-4 days years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from OCT. 3, 1956 to OCT. 13, 1956 , that I last saw the deceased alive on OCT. 13, 1956 , and that death occurred at 5:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles W. Ward</i> M.D.		ADDRESS (Street, city or town, state) 10/15/56 DATE SIGNED	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	22b. DATE THEREOF 10/16/56	22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i> ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR OCT 17 1956	24b. REGISTRAR'S SIGNATURE <i>J. E. Barry</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2130

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. If burial, cremation, or removal, file pages 1 and 2 with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

099990/40

10016 Items 2, 13, 14 Film G206 11-2-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belair Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u> 75X-3	
f. STREET ADDRESS <u>621 Green Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Russel Charles De Esch</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER 8 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-31</u>
9. AGE (In years last birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ensign</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. DeEsch</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Acker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>currently</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>U S Navy</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussive & lacerative Brain injury</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Head wounds & contrecoup forces</u> DUE TO (c) <u>Sustained in car crash.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Just</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crush injury of chest.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>CAR CRASHED INTO WALL</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:30 a.m. 10-8-56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Kingsville Balto Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John C. Hyle</u>		DATE SIGNED <u>10-8-56</u>	
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>10-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>to</u>	22d. LOCATION (City, town, or county) (State) <u>Emmaus, Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>DATE 15 1956</u>	
ADDRESS <u>ANNAPOLIS, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. H. H. H. H.</u>	

RECEIVED

OCT 15 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09991 30

10017

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr3mth15dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Box 1-Rt.1-Agushart Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Rosina Rose Rosie Diller				4. DATE OF DEATH Month Day Year October 2, 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1864		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emil ?				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 902.7 Fractured left hip							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) to floor sustaining fractured left hip. On 9-17-56 pt. fell					
20c. TIME OF INJURY Month, Day, Year Hour 4:30 P.M. Sept. 17 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer				DATE SIGNED 10-2-56			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 4 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Richie Highway Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dippel Brothers				ADDRESS 1800 E Lombard Street		24a. REC'D BY REGISTRAR OCT 4 1956	
				24b. REGISTRAR'S SIGNATURE T. E. Harry			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. The funeral director, registrar, or removal.

9561 7 OCT

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in pages 1 and 2 and file with the
funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the
registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09992

10018

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armaccost Nursing Home 812 Register Ave.		d. STREET ADDRESS Wiltondale 309 Weatherbee Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SARAH Middle BERTHA Last DORSEY		4. DATE OF DEATH Month Oct. Day 5, Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1888
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Dorsey		14. MOTHER'S MAIDEN NAME Florence Burgess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-1827	
17. INFORMANT Mrs. Charles A. Chrow - 309 Weatherbee Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma (Generalized) 171X DUE TO Carcinoma of Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1956 to October 5, 1956 , that I last saw the deceased alive on October 4, 1956 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd DATE SIGNED 10/5/56	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell		MD Lawson #4 Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tidner & Sons - Balto 17 Md		24a. REC'D BY REGISTRAR DATE October 6, 1956	
24b. REGISTRAR'S SIGNATURE R-45 Mabel King			

BUREAU V. B.

OCT 8 1956

RECEIVED

10019

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 2yrs. 2mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Silver Cross Nursing Home				d. STREET ADDRESS 402 Random Road			
3. NAME OF DECEASED (Type or print) ANNA M. DRISCOLL				4. DATE OF DEATH Month October Day 13 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Middleburg-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Myers				14. MOTHER'S MAIDEN NAME Sally L. Hahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Norman C. Cremer--402 Random Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy and 353.3 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic Myocarditis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 yrs. 1 yr. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 10-21 , 19 54 , to 10-13 , 19 54 , that I last saw the deceased alive on 10-13 , 19 56 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 10-17-56							
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.					
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct: 17:1956		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Nippert		ADDRESS 1300 Eutaw Place.		24a. REC'D BY REGISTRAR DATE Oct. 18, 1956		24b. REGISTRAR'S SIGNATURE Mary Eline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, and the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09994

CERTIFICATE OF DEATH

Reg. Dist. No.

37

10020

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY 69X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City (formerly of)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEILA Middle THORNTON Last DUDLEY		4. DATE OF DEATH Month Oct. Day 17 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter Dudley		14. MOTHER'S MAIDEN NAME Mary Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 090-09-6602	
17. INFORMANT Mr. Dudley H. Grape - 7303 Yorktown Drive		Address Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage Hemiplegia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. , 19 55 , to Oct 17 , 19 56 , that I last saw the deceased alive on Oct 16 , 19 56 , and that death occurred at 12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William F. Pearce M.D. PHYSICIAN'S NAME (Type) WILLIAM F PEARCE 2105 N. Charles St.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/19/56	
22c. NAME OF CEMETERY OR CREMATORY Spring Grove Cem.		22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. 17. Ind.		24a. REC'D BY REGISTRAR DATE OCT 22 1956	
24b. REGISTRAR'S SIGNATURE Ernest MacRae			

BUREAU V. S.

OCT 22 1956

RECEIVED
OCT 28 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09995 44

10021

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 24 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle DURLING Last DURLING				4. DATE OF DEATH Month October Day 1 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 29, 1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Air Craft		11. BIRTHPLACE (State or foreign country) Milford, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Durling				14. MOTHER'S MAIDEN NAME Esther Silcox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW-I				16. SOCIAL SECURITY NO. 169-14-3245		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPHYSEMA, RIGHT 521x DUE TO ABSCCESS, RIGHT LOWER LOBE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO INFARCTION, RIGHT LOWER LOBE (c) INTERVAL BETWEEN ONSET AND DEATH 1 WEEK UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction due to arteriosclerotic coronary thrombosis duration unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 7, 1956 , to October 1, 1956 , that I saw the deceased alive on September 19, 1956 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/2/56 ACTUAL SIGNATURE Irving Freeman M.D. IRVING FREEMAN, M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home, 7401 Belair Rd., Balto., Md.				24a. REC'D BY REGISTRAR DATE 9 1956		24b. REGISTRAR'S SIGNATURE Lessahn L. Fairley	

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09996

43

10022

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Silver Spring Road</u>				d. STREET ADDRESS <u>Silver Spring Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Mrs. Millie</u> Middle <u>Berry</u> Last <u>Fink</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> st Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/15/1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				13. FATHER'S NAME <u>Thomas C. Spurrier</u>			
14. MOTHER'S MAIDEN NAME <u>?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mr. John Adam Fink, Silver Spring Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma uteri</u> <u>174x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Oct 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>56</u> , and that death occurred at <u>1 A</u> .M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>1 W. Overles Ave.</u> <u>10-31-56</u>				PHYSICIAN'S NAME (Type) <u>Dr. Richard R. Rigler</u> <u>Balto. 6, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>NOV - 1 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Heyn</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. MARITAL STATUS		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF TOWNSHIP CLERK		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF STATE CLERK		24. SIGNATURE OF SECRETARY OF HEALTH		25. SIGNATURE OF ASSISTANT SECRETARY OF HEALTH		26. SIGNATURE OF CHIEF OF BUREAU		27. SIGNATURE OF DEPUTY CHIEF OF BUREAU		28. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		29. SIGNATURE OF CLERK OF BUREAU		30. SIGNATURE OF TYPIST		31. SIGNATURE OF RECEPTIONIST		32. SIGNATURE OF MAIL ROOM		33. SIGNATURE OF TELEPHONE ROOM		34. SIGNATURE OF RECORDS ROOM		35. SIGNATURE OF GENERAL INVESTIGATIVE DIVISION		36. SIGNATURE OF LABORATORY		37. SIGNATURE OF RADIOLOGICAL DEPARTMENT		38. SIGNATURE OF PATHOLOGICAL DEPARTMENT		39. SIGNATURE OF ANATOMICAL DEPARTMENT		40. SIGNATURE OF PHYSIOLOGICAL DEPARTMENT		41. SIGNATURE OF CLINICAL DEPARTMENT		42. SIGNATURE OF SURGICAL DEPARTMENT		43. SIGNATURE OF MEDICAL DEPARTMENT		44. SIGNATURE OF DENTAL DEPARTMENT		45. SIGNATURE OF VETERINARY DEPARTMENT		46. SIGNATURE OF PHARMACEUTICAL DEPARTMENT		47. SIGNATURE OF BOTANICAL DEPARTMENT		48. SIGNATURE OF ZOOLOGICAL DEPARTMENT		49. SIGNATURE OF AGRICULTURAL DEPARTMENT		50. SIGNATURE OF FISHERIES DEPARTMENT		51. SIGNATURE OF MINERAL DEPARTMENT		52. SIGNATURE OF METEOROLOGICAL DEPARTMENT		53. SIGNATURE OF AERONAUTICAL DEPARTMENT		54. SIGNATURE OF NAUTICAL DEPARTMENT		55. SIGNATURE OF MARINE DEPARTMENT		56. SIGNATURE OF COAST AND GEODETIC SURVEY		57. SIGNATURE OF BUREAU OF Lighthouses and Harbors		58. SIGNATURE OF BUREAU OF Navigation		59. SIGNATURE OF BUREAU OF Census and Statistics		60. SIGNATURE OF BUREAU OF Education		61. SIGNATURE OF BUREAU OF Labor and Industry		62. SIGNATURE OF BUREAU OF Social Welfare		63. SIGNATURE OF BUREAU OF Public Health		64. SIGNATURE OF BUREAU OF Mental Hygiene		65. SIGNATURE OF BUREAU OF Child Welfare		66. SIGNATURE OF BUREAU OF Family Services		67. SIGNATURE OF BUREAU OF Juvenile Delinquency		68. SIGNATURE OF BUREAU OF Probation and Parole		69. SIGNATURE OF BUREAU OF Prison and Prisoners		70. SIGNATURE OF BUREAU OF Police		71. SIGNATURE OF BUREAU OF Fire		72. SIGNATURE OF BUREAU OF Public Safety		73. SIGNATURE OF BUREAU OF State Police		74. SIGNATURE OF BUREAU OF State Troop		75. SIGNATURE OF BUREAU OF State Militia		76. SIGNATURE OF BUREAU of National Guard		77. SIGNATURE OF BUREAU OF National Guard Reserve		78. SIGNATURE OF BUREAU OF National Guard Auxiliary		79. SIGNATURE OF BUREAU OF National Guard Cadet		80. SIGNATURE OF BUREAU OF National Guard Officer		81. SIGNATURE OF BUREAU OF National Guard Sergeant		82. SIGNATURE OF BUREAU OF National Guard Private		83. SIGNATURE OF BUREAU OF National Guard Corporal		84. SIGNATURE OF BUREAU OF National Guard Lieutenant		85. SIGNATURE OF BUREAU OF National Guard Captain		86. SIGNATURE OF BUREAU OF National Guard Major		87. SIGNATURE OF BUREAU OF National Guard Colonel		88. SIGNATURE OF BUREAU OF National Guard Lieutenant Colonel		89. SIGNATURE OF BUREAU OF National Guard Major General		90. SIGNATURE OF BUREAU OF National Guard Brigadier General		91. SIGNATURE OF BUREAU OF National Guard Division General		92. SIGNATURE OF BUREAU OF National Guard Corps General		93. SIGNATURE OF BUREAU OF National Guard Division General		94. SIGNATURE OF BUREAU OF National Guard Corps General		95. SIGNATURE OF BUREAU OF National Guard Division General		96. SIGNATURE OF BUREAU OF National Guard Corps General		97. SIGNATURE OF BUREAU OF National Guard Division General		98. SIGNATURE OF BUREAU OF National Guard Corps General		99. SIGNATURE OF BUREAU OF National Guard Division General		100. SIGNATURE OF BUREAU OF National Guard Corps General	
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BUREAU V. B.

NOV 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09997

10023

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yr5mth2dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Orilla Middle S. E. Last Firor				4. DATE OF DEATH Month October Day 16 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1881	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Stansbury				14. MOTHER'S MAIDEN NAME Mary E. Bull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no yes (If yes, give year or dates of service) World War #1		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 14, 1954 , to Oct. 16, 1956 , that I last saw the deceased alive on October 16, 1956 , and that death occurred at 10:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-17-56					
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/20/56	22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickener & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE Oct. 18, 1956		24b. REGISTRAR'S SIGNATURE T. E. Barry	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
PLACE OF DEATH		CITY OF DEATH	
MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
AGE		SEX	
35		MALE	
RACE		OCCUPATION	
WHITE		ATTORNEY	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		PLACE OF BIRTH	
JANUARY 19, 1933		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL CAUSE	
CORONARY THROMBOSIS		NOT A SUICIDE	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
APRIL 4, 1968		MEMPHIS, TENNESSEE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. S.

OCT 19 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09998

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Parkville) x</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2815 LINWOOD AVE</u>		d. STREET ADDRESS <u>2815 linwood Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Leonard</u> First <u>Fleischman</u> Middle <u>Heinrich</u> Last		4. DATE OF DEATH <u>October 8</u> Month <u>1956</u> Day <u>8</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 May 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST- CONT. CAN CO.</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE ITNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>215-03-3710</u>	
17. INFORMANT <u>MRS Rosa Fleischmann</u> Address		12. CITIZEN OF WHAT COUNTRY? <u>Yes USA 1932</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Atherosclerosis Generalized</u> (a), stating the underlying cause lost. DUE TO (c) <u>Undet</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma Chronic</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John C. Hyle</u>		DATE SIGNED <u>10-8-56</u>	
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/10/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Kuck</u> ADDRESS <u>5545 Bayford</u>		24a. REC'D BY REGISTRAR <u>DATE Oct. 10, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Bacon</u>	

MEDICAL CERTIFICATION

BUREAU V. S.

OCT 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09999

10025

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital	
d. STREET ADDRESS 1620 Druid Hill Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OTIS Middle Last FLEMING		4. DATE OF DEATH Month October Day 30 Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Confectionery	
11. BIRTHPLACE (State or foreign country) Lancaster Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leonard R. Fleming		14. MOTHER'S MAIDEN NAME Sarah Griffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 218-03-0394	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUBERCULOSIS, PULMONARY, CHRONIC, FAR ADVANCED DUE TO (b) 002X DUE TO (c) 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 22, 19 56 , to October 30, 19 56 , that I last saw the deceased 10:40 A.M. and that death occurred at 10:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis G. Dickey		DATE SIGNED 10/31/56	
PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, Chief, Medical Service, VAH, Fort Howard, Maryland		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802-04 Madison Ave. Baltimore 1, Md.	
24a. REC'D BY REGISTRAR 11/3/56		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be relayed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		35		Jan 15, 1921		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Marital Status		Date of Marriage		Date of Death		Time of Death		Place of Death		Physician's Signature	
Teacher		High School		Married		Jan 1, 1945		Jan 10, 1956		10:00 AM		St. Mary's Hospital		J. Smith, M.D.	
Signature of Informant		Relationship to Deceased		Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Undertaker	
John Doe		Son		J. Smith		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe	

BUREAU V. 8

NOV 7 1956

RECEIVED

10026 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

10000
 Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk, Maryland			c. LENGTH OF STAY IN 1b 12 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7524 Holabird Ave.				d. STREET ADDRESS 7524 Holabird Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) HOLDEN CAMPBELL FORSYTHE				4. DATE OF DEATH Month 10 Day 21 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1908		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel Mfr.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel C. Forsythe				14. MOTHER'S MAIDEN NAME Victoria Knox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-6349		17. INFORMANT Robert D. Forsythe Address - same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-19 , 19 56 , to 10-21 , 19 56 , that I last saw the deceased alive on 10-21 , 19 56 , and that death occurred at 7:45 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack C. Collins				ADDRESS (Street, city or town, state) 2 Kent St Baltimore 22		DATE SIGNED 10-22-56	
PHYSICIAN'S NAME (Type) Jack C. Collins							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-24-56		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John B. Bradley				ADDRESS Dundalk, Maryland		24a. REC'D BY REGISTRAR DATE 24 1956	
				24b. REGISTRAR'S SIGNATURE Sawson L. Harber			

OCT 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10027 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10001 28
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stoneleigh</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stoneleigh</i>	
c. LENGTH OF STAY IN 1b <i>30 yrs.</i>		d. STREET ADDRESS <i>6503 Maplewood Rd</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6503 Maplewood Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ROBERT E FOUTZ</i>		4. DATE OF DEATH <i>Oct 23 1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 5, 1877</i>
9. AGE (In years last birthday) <i>79</i>		IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Business</i>	
11. BIRTHPLACE (State of foreign country) <i>Johnsville, Frederick Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Solomon S Foutz</i>		14. MOTHER'S MAIDEN NAME <i>Mary Naille</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-18-0677</i>	
17. INFORMANT <i>Mrs Mary L Crowford</i>		Address <i>Westminster Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Decompositional Cardio Vascular Disease</i> DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1</i> , 19 <i>56</i> , to <i>Oct 23</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Oct 23</i> , 19 <i>56</i> , and that death occurred at <i>7:40</i> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Laurence C. Post</i>		ADDRESS (Street, city or town, state) <i>6805 York Rd. Baltimore 12 Md.</i>	
PHYSICIAN'S NAME (Type) <i>LAURENCE C. POST</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 25 1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ebenezer</i>		22d. LOCATION (City, town, or county) (State) <i>Stinfield Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W Jenkins & Sons Co</i>		ADDRESS <i>4905 York Rd</i>	
24a. REC'D BY REGISTRAR <i>Oct 25 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>OCT 28 1956</i>	
5. PLACE OF DEATH <i>HOME</i>		6. COUNTY <i>BALTIMORE</i>		7. CITY <i>BALTIMORE</i>		8. STATE <i>MARYLAND</i>	
9. OCCUPATION <i>CLERK</i>		10. MARITAL STATUS <i>MARRIED</i>		11. PLACE OF BIRTH <i>NEW YORK</i>		12. DATE OF BIRTH <i>APR 15 1911</i>	
13. CAUSE OF DEATH <i>HEART DISEASE</i>		14. MANNER OF DEATH <i>NATURAL</i>		15. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		16. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		19. SIGNATURE OF WITNESS <i>[Signature]</i>		20. SIGNATURE OF WITNESS <i>[Signature]</i>	

RECEIVED
OCT 29 1956
BUREAU Y. S.

10028

CERTIFICATE OF DEATH

10002

Reg. Dist. No.

31

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1749 LITTLE CREEK DR				d. STREET ADDRESS 1749 LITTLE CREEK DR.			
3. NAME OF DECEASED (Type or print) ALBERT B. FOX				4. DATE OF DEATH Month 10 - Day 18 - Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-1908	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT BUYER				10b. KIND OF BUSINESS OR INDUSTRY EDDIES SUP. MKT		11. BIRTHPLACE (State or foreign country) PHILADELPHIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph FOX				14. MOTHER'S MAIDEN NAME IDA KLINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 146-03-2490		17. INFORMANT Address MARY E. FOX 1479 LITTLE CREEK			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 153X DUE TO Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 18 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from April 27 , 19 53 , to Oct 18 , 19 56 , that I last saw the deceased alive on Oct 18 , 19 56 , and that death occurred at 5 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis Blum, M.D.				ADDRESS (Street, city or town, state) 2310 Eutanw Plue Baltimore, Md.			
PHYSICIAN'S NAME (Type) Louis U. Blum				DATE SIGNED Oct 24 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 10/22/56		22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE J. T. STANSBURY				24. REC'D BY REGISTRAR DATE Oct 24 1956			
25. REGISTRAR'S SIGNATURE Dr. H. M. Martin							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10003

Reg. Dist. No.

10029

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPARROWS POINT HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gillespie, Jesse First BOYD Middle Gillespie Last				4. DATE OF DEATH Month 10 Day 27 Year 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 13, 1906	
9. AGE (In yrs. last birthday) 49		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Maintenance				10b. KIND OF BUSINESS OR INDUSTRY Steel Mfg.		11. BIRTHPLACE (State or foreign country) Henry Co., Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas I. Gillespie				14. MOTHER'S MAIDEN NAME Belle Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 242-05-4663		17. INFORMANT Mrs. Edith R. Gillespie-401 Edsdale Rd., Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 (c) 5 min. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK C. COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 30, 1956		22c. NAME OF CEMETERY OR CREMATORY SHERWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) ROANOKE, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER AND SONS, BALTIMORE, MD.				24a. REC'D BY REGISTRAR OCT 29 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Harber	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 30 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relayed by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10004

10030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hill Nursing Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth First Ann Gladfelter Last		4. DATE OF DEATH Oct Month 10 Day Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1868
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Talbott		14. MOTHER'S MAIDEN NAME Susan Daily	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	17. INFORMANT Family records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) 2 days 2 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 8, 1956 to Oct 10, 1956 that I last saw the deceased alive on Oct 9, 1956 , and that death occurred at 5:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. M. Baumgardner M.D. Balto 6 Md		DATE SIGNED 10/10/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 13, 1956	22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery,	22d. LOCATION (City, town, or county) (State) Shrewsbury, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons,		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR DATE 10/15/56		24b. REGISTRAR'S SIGNATURE Edith Stiles	

10031

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>40 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>611 Harlem Ave</u>				d. STREET ADDRESS <u>same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gertrude M. Glanville</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John DeGraff</u>				14. MOTHER'S MAIDEN NAME <u>Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Gertrude Hipson</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE UTERUS</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(OPERATION AND METASTASES)</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3</u> <u>2</u> YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG, 18</u> , 19 <u>53</u> , to <u>OCT, 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>OCT, 19</u> , 19 <u>56</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>6348 FREDERICK ROAD</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>S. LLOYD JOHNSON, M.D. 6348 FREDERICK ROAD, CATONSVILLE, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/23/56</u>		<u>Lorraine</u>		<u>Balto Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. W. Ruff + Son</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>10/24/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. E. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10032 CERTIFICATE OF DEATH

Reg. Dist. No. 10006

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Rural: Towson**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **Eudowood Sanatorium
 Towson 4, Maryland**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTY **Baltimore**
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Lutherville**
 STREET ADDRESS (If rural give location) **504 Spring Avenue**

3. NAME OF DECEASED:

(First) **HARTWELL** (Middle) **D.** (Last) **GLASS**

4. DATE OF DEATH: (Month) (Day) (Year)
October 25, 1956

5. SEX:

MALE

6. COLOR OR RACE:

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

8. DATE OF BIRTH:

12-25-26

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

29 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY:

MECHANICAL ENGINEER Virginia

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME:

JAMES B. GLASS

14. MOTHER'S MAIDEN NAME:

ANNA RICHARDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

yes **World War II**

16. SOCIAL SECURITY NO.:

231-24-6461

17. INFORMANT & ADDRESS: **Personal History
 Hospital Records, Eudowood Sanatorium**

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

DUE TO

Adenocarcinoma left lung

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(c)

Interval Between Onset And Death
18 mos.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

7/26/56**Lymph nodes showed**

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

m.

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-2-56** to **10/25-56**, that I last saw the deceased alive on **10/25-56**, and that death occurred at **5:50 PM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Milton B. Kues**Eudowood Sanatorium - Towson 4, Maryland**

23. BURIAL, CREMATION, REMOVAL (Specify)

Removal

DATE THEREOF

Oct. 26, 1956

NAME OF CEMETERY OR CREMATORY

John M. Oakey Funeral Home

LOCATION (City, town, or county)

Roanoke, Virginia

(State)

DATE REC'D BY LOCAL REGISTRAR

Oct. 26, 1956

REGISTRAR'S SIGNATURE

Mabel C. Gray

FUNERAL DIRECTOR

John Barnes' Sons

ADDRESS

Towson, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10007

10033

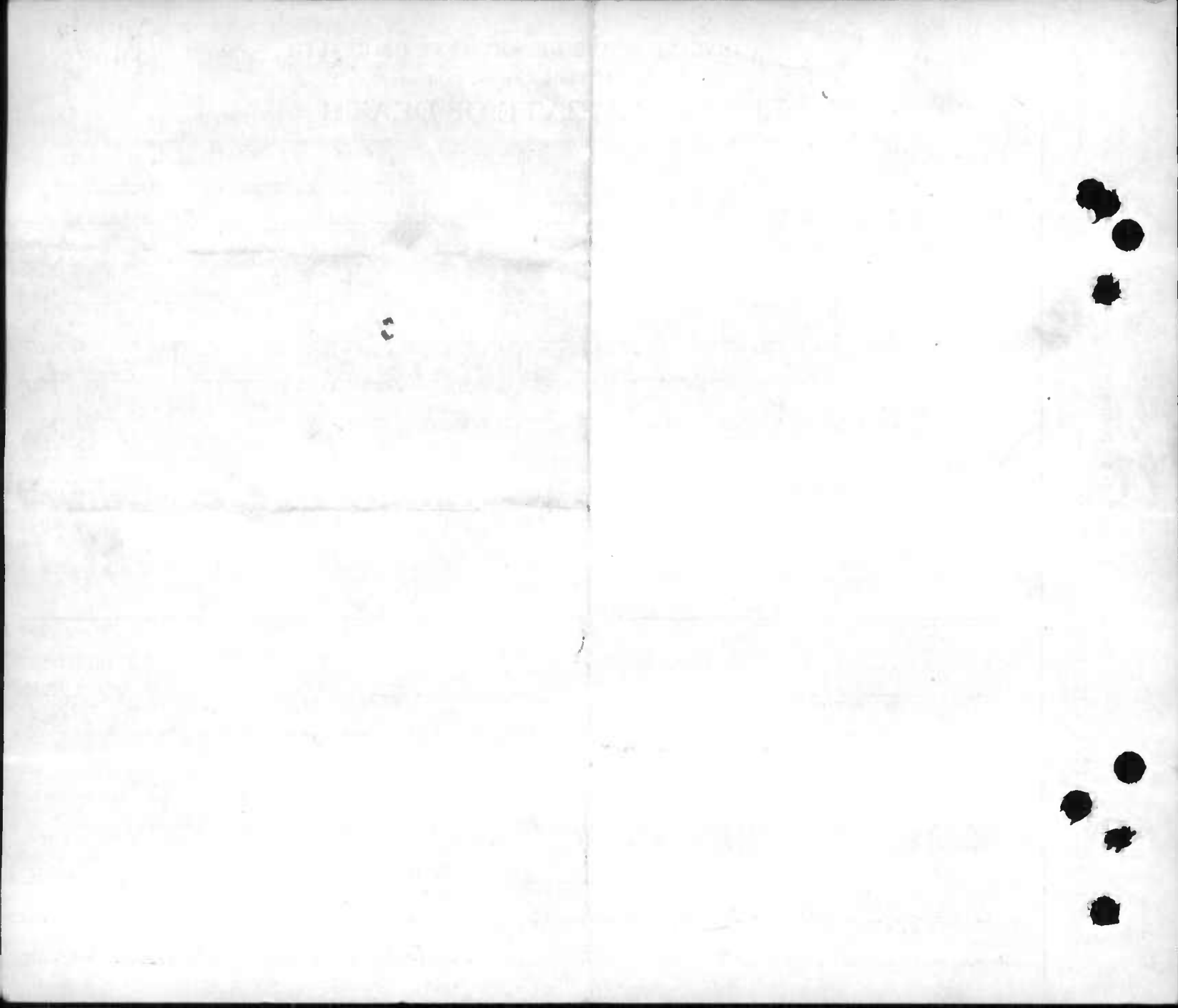
CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Baltimore</u> LENGTH OF STAY (in this place) <u>11 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7400 Belmont Avenue</u>		STREET ADDRESS (If rural give location) <u>7400 Belmont Ave</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>A.</u> (Last) <u>Goldys</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>21</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/12/1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Still Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>J. S. Young Co.</u>	9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>Poland</u>	
13. FATHER'S NAME <u>John Andrew Goldys</u>		14. MOTHER'S MAIDEN NAME <u>Sophia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-10-0983</u>	
17. INFORMANT <u>Mary Goldys 7400 Belmont Ave</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4221 Immediate cause (a) <u>Cerebral Vascular Accidents</u>		<u>7 days</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic cardiovascular disease</u>		<u>> 10 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>did not</u> , 19....., to <u>NEVER</u> , 19....., that I last saw the deceased alive on <u>4 A</u> , 19....., and that death occurred at <u>4 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>David A. Levy M.D.</u> (Degree or title)		ADDRESS <u>434 Eastern Ave, Essex Md</u> DATE SIGNED <u>10/21/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>10/24/56</u> NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u> LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>			
DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. S. Fialkowski</u> ADDRESS <u>2007 Eastern Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10008

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 10034 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>Visiting</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lyons Mill Road</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>South Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLINTON LYNCH GOODWIN</u>			4. DATE OF DEATH Month Day Year <u>OCT. 15, 1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25, 1888</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Veterinary</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Franklin P. Goodwin</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown Josephine Bosley</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> <u>W.W.#1</u>		
16. SOCIAL SECURITY NO. <u>220-34-7320</u>			17. INFORMANT <u>Francis Goodwin (Wife)</u> <u>Pikesville, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u> </u> DUE TO (c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) <u>none</u>	(County) <u> </u>	(State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>D. D. Caples</u> EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DATE SIGNED <u>10-17-56</u>			22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		
22b. DATE THEREOF <u>10-18, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell - Pikesville 8. Md.</u>			24a. REC'D BY REGISTRAR <u>DATE OCT 19 1956</u>		
24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>			25. (City or town) <u> </u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text elements.

BUREAU V. S.

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10035

CERTIFICATE OF DEATH

Reg. Dist. No. 10009 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2904 Hillcrest Avenue</i>		d. STREET ADDRESS <i>743 Linnard Street</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Agnes Estella Gourley</i>		4. DATE OF DEATH <i>October 2nd 19 56</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 10, 1883</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Nicholson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Timmins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Mary Kram</i>		Address <i>2904 Hillcrest Avenue #14</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pancreatic Carcinoma</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malnutrition and Paralytic illness</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>56</i> , to <i>10-2</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>10-1</i> , 19 <i>56</i> , and that death occurred at <i>3:06</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Hyle</i>		ADDRESS (Street, city or town, state) <i>1527 Belair Rd</i> DATE SIGNED <i>10-2-56</i>	
PHYSICIAN'S NAME (Type) <i>JOHN C. Hyle</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/5/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>OCT 5 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10010

Reg. Dist. No.

10036

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		STATE <u>MD</u> COUNTY <u>BALTO</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN		<u>8 YEARS</u>		TOWN <u>ROSEDALE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>1538 ROSEWICK AVE</u>				<u>1538 ROSEWICK AVE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>E</u> (Last) <u>BRANVILLE</u>				(Month) <u>10</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>W</u>	<u>NOV 13, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>AT HOME</u>					<u>BALTO. MD</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>LAWRENCE KNOBEL</u>				<u>CATHERINE LETCHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>1538 ROSEWICK ELIZABETH SCHMAELZLE AVE</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1420.0 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1954</u> to <u>Oct. 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 30</u> , 19 <u>56</u> , and that death occurred at <u>8:55a</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James R. Mann, M.D.</u>				ADDRESS (Street, city, town, state) <u>8019 Philadelphia Rd. Baltimore 6, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11/2/56</u>		<u>ZION EVAN. CENT</u>		<u>STEMMERS RUN. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>NOV 5 1956</u>		<u>Edith Shirley</u>		<u>Lawrence F. Hoffman</u>		<u>3218 Hudson St</u>	

CERTIFICATE OF DEATH

0036

1956

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Time of death (Hour, minute)

7. Cause of death (List all causes, beginning with immediate cause)

8. Place of death (City, State, Country)

9. Signature of physician (Print name and sign)

10. Signature of registrar (Print name and sign)

11. Signature of informant (Print name and sign)

12. Date of filing (Month, day, year)

13. File number (Print or write)

14. Date of death (Month, day, year)

15. Time of death (Hour, minute)

16. Cause of death (List all causes, beginning with immediate cause)

17. Place of death (City, State, Country)

18. Signature of physician (Print name and sign)

19. Signature of registrar (Print name and sign)

20. Signature of informant (Print name and sign)

21. Date of filing (Month, day, year)

22. File number (Print or write)

23. Date of death (Month, day, year)

24. Time of death (Hour, minute)

25. Cause of death (List all causes, beginning with immediate cause)

26. Place of death (City, State, Country)

27. Signature of physician (Print name and sign)

28. Signature of registrar (Print name and sign)

29. Signature of informant (Print name and sign)

BUREAU V. 3

NOV 5 1956

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS Rt.#1 Box 442 A			
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last GREEN				4. DATE OF DEATH Month October Day 11 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1887		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer unemployed			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Green				14. MOTHER'S MAIDEN NAME Harriett Jilling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. 243-22-0418		17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE- Duration Unknown							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 5, 1956 , to October 11, 1956 , and that death occurred at 12:50 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND 10/11/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, Chief Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORY Annapolis National		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, 108 Washington St., Annapolis, Md.				24a. REC'D BY REGISTRAR 15 1956		24b. REGISTRAR'S SIGNATURE James L. Harkins	

10012
Inst. No. 40

Reg. Dist. No.

10038

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KINGSVILLE		c. LENGTH OF STAY IN 1b KINGSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CHAPMAN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle C Last GRIFFIN		4. DATE OF DEATH Month OCT. Day 19 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 13 - 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 6 Days 3 Hours 0 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		12. KIND OF BUSINESS OR INDUSTRY OWN	
13. BIRTHPLACE (State or foreign country) BALTO. MD.		14. CITIZEN OF WHAT COUNTRY? ABOVE	
15. FATHER'S NAME HARRY GRIFFIN		16. MOTHER'S MAIDEN NAME ALMIRE DREBEN	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. 215-32-0143	
19. INFORMANT ANNA GRIFFIN		20. ADDRESS ABOVE	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 250.1 (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Diabetes		22. INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 20 yrs.	
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
27. TIME OF INJURY Hour a. p. 19 Month, Day, Year		28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
29. (City or town) Kingsville, Md.		30. (County) (State)	
31. I certify that I attended the deceased from Oct. 19, 1956 , to Oct. 19, 1956 , that I last saw the deceased alive on Oct. 19, 1956 , and that death occurred at 2:50 M, from the causes and on the date stated above.		32. ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 10-20	
33. ACTUAL SIGNATURE William A. Tyson M.D.		34. PHYSICIAN'S NAME (Type) William A. Tyson	
35. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		36. DATE THEREOF OCT. 22-56	
37. NAME OF CEMETERY OR CREMATORY MORELAND PARK		38. LOCATION (City, town, or county) (State) BALTO. MD.	
39. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly		40. ADDRESS 418 Eastern Ave., Essex 21-Md.	
41. REC'D BY REGISTRAR OCT 24 1956		42. REGISTRAR'S SIGNATURE Dr. Walter H. M... ..	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/55

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10013

Reg. Dist. No.

30

10039

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 19yrs2mt26dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Grimes Last Grimes				4. DATE OF DEATH Month October Day 24 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 71? yrs.	IF UNDER 1 YEAR Months 71? Days 71? Hours 71? Min. 71?	IF UNDER 24 HRS. Months 71? Days 71? Hours 71? Min. 71?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic vascular disease DUE TO Chronic vascular disease (c) Chronic vascular disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X Diabetes Mell.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ERROR					
20c. TIME OF INJURY Month, Day, Year 6-30-56 19 56 Hour 3:24 a.m.		20d. INJURY OCCURRED While at work Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work		20f. (City or town) Catonsville (County) Howard (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		DATE SIGNED 10-24-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-56		22c. NAME OF CEMETERY OR CREMATORY Jennings Chapel		22d. LOCATION (City, town, or county) (State) Florence, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR DATE 20 10 56	
				24b. REGISTRAR'S SIGNATURE F. C. Higinbotham			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 582 W. Balto. Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle T. Last GROVE		4. DATE OF DEATH Month October Day 20 Year 1956	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/20/93 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Creamery Company 11. BIRTHPLACE (State or foreign country) Altantic, Iowa 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John E. Grove 14. MOTHER'S MAIDEN NAME Dora Hodges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service WW-I 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE AURICULAR AND VENTRICULAR FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNDIFFERENTIATED BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE BRONCHUS WITH METASTASIS TO VERTEBRAE INTERVAL BETWEEN ONSET AND DEATH SUDDEN UNDETERMINED			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 15, 1956 , to October 19, 1956 and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D. VAH, Fort Howard, Maryland 10/20/56 PHYSICIAN'S NAME (Type) ROLANDO D. PONCE DE LEON VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/23/56 22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery 22d. LOCATION (City, town, or county) (State) Westminster, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Harvey Bankart & Sons Funeral Home Main Street Westminster, Maryland 24a. REC'D BY REGISTRAR DATE 10/20-56 24b. REGISTRAR'S SIGNATURE Henry B. Shreve Howard L. Shreve	

may be retained by the hospital or attending physician.

ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AP

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Name] 2. SEX: [Sex] 3. AGE: [Age]

4. DATE OF BIRTH: [Date] 5. PLACE OF BIRTH: [Place]

6. OCCUPATION: [Occupation] 7. MARITAL STATUS: [Status]

8. CAUSE OF DEATH: [Cause] 9. PLACE OF DEATH: [Place]

10. TIME OF DEATH: [Time] 11. SIGNATURE OF DECEASED: [Signature]

12. SIGNATURE OF WITNESSES: [Signatures] 13. SIGNATURE OF DOCTOR: [Signature]

14. SIGNATURE OF REGISTRAR: [Signature] 15. DATE OF REGISTRATION: [Date]

16. PLACE OF REGISTRATION: [Place] 17. OFFICIAL USE ONLY

18. REMARKS: [Remarks] 19. SIGNATURE OF REGISTRAR: [Signature]

20. DATE OF REGISTRATION: [Date] 21. PLACE OF REGISTRATION: [Place]

22. OFFICIAL USE ONLY 23. SIGNATURE OF REGISTRAR: [Signature]

24. DATE OF REGISTRATION: [Date] 25. PLACE OF REGISTRATION: [Place]

26. OFFICIAL USE ONLY 27. SIGNATURE OF REGISTRAR: [Signature]

28. DATE OF REGISTRATION: [Date] 29. PLACE OF REGISTRATION: [Place]

30. OFFICIAL USE ONLY 31. SIGNATURE OF REGISTRAR: [Signature]

32. DATE OF REGISTRATION: [Date] 33. PLACE OF REGISTRATION: [Place]

34. OFFICIAL USE ONLY 35. SIGNATURE OF REGISTRAR: [Signature]

36. DATE OF REGISTRATION: [Date] 37. PLACE OF REGISTRATION: [Place]

38. OFFICIAL USE ONLY 39. SIGNATURE OF REGISTRAR: [Signature]

40. DATE OF REGISTRATION: [Date] 41. PLACE OF REGISTRATION: [Place]

42. OFFICIAL USE ONLY 43. SIGNATURE OF REGISTRAR: [Signature]

44. DATE OF REGISTRATION: [Date] 45. PLACE OF REGISTRATION: [Place]

46. OFFICIAL USE ONLY 47. SIGNATURE OF REGISTRAR: [Signature]

BUREAU V. S.

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG20611-14-56 et
CERTIFICATE OF DEATH

10015

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 31014			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City (12)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home-Harlem Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JENNIE Middle WILHEMINA Last HAMBRAUCH				4. DATE OF DEATH Month Oct. Day 27, Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Sauble				14. MOTHER'S MAIDEN NAME Jennie Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Viola Kendall - 2300 E. Fayette St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General debility secondary DUE TO (c) to Cancer of the ovary						INTERVAL BETWEEN ONSET AND DEATH 2 days - 5 months - 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June , 19 52 , to OCT 27 , 19 56 , that I last saw the deceased alive on OCT 26 , 19 56 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson Ave DATE SIGNED 10/26/56							
ACTUAL SIGNATURE Cliff Ratliff, Jr. M.D.				PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/31/56		22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cem.	
22d. LOCATION (City, town, or county) Westminster, Md.				22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17, Md.				23a. REC'D BY REGISTRAR DATE 10/1/56		23b. REGISTRAR'S SIGNATURE T. E. Harry	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN		APR 4 1968		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. FULL NAME OF REGISTRAR		14. FULL NAME OF WITNESS		15. FULL NAME OF SIGNATURE		16. FULL NAME OF SIGNATURE		17. FULL NAME OF SIGNATURE		18. FULL NAME OF SIGNATURE		19. FULL NAME OF SIGNATURE		20. FULL NAME OF SIGNATURE		21. FULL NAME OF SIGNATURE		22. FULL NAME OF SIGNATURE		23. FULL NAME OF SIGNATURE		24. FULL NAME OF SIGNATURE	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film 4206 11-2-56 et

CERTIFICATE OF DEATH

10016

10042

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sparrows Point</u>		<u>26 years</u>		TOWN <u>Sparrows Point Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 311 Penwood Ave</u>				STREET ADDRESS (If rural give location) <u>Box 311 Penwood Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George Ellwood Hammond</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 24 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 26-1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roll-setter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Middletown-Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer Ellsworth Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Anna M. Cain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-8479</u>		17. INFORMANT & ADDRESS <u>Bertha B. Hammond Box 311 Penwood Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Heart Failure</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>Oct 24, 1956</u> , that I last saw the deceased alive on <u>Oct 23, 1956</u> , and that death occurred at <u>6:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. B. Linn</u>		M. D. <u>520 Dist. Sp. F. 17 Ind. 102516</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. REC'D BY REGISTRAR DATE <u>OCT 29 1956</u>		REGISTRAR'S SIGNATURE <u>Lawson L. Larkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sassahm Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Use. 15

1. DECEASED'S NAME (Print or Write)

2. SEX
3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CLERK

BUREAU V. S.

OCT 29 1956

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ENCLOSURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10017

10043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent		d. STREET ADDRESS 1001 West Joppa Road	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Boda (Hanly)		4. DATE OF DEATH Month Day Year Oct. 5, 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1874
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	
11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy Hanly		14. MOTHER'S MAIDEN NAME Mary Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 West Joppa Rd. Towson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 8, 1956 to October 5, 1956 , that I last saw the deceased alive on October 4, 1956 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell		ADDRESS (Street, city or town, state) 7501 York Road	
DATE SIGNED 10/6/56			
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		ADDRESS 7501 York Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1956	
22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemmon		ADDRESS 4611 Park Heights Ave.	
DATE Oct 8 1956		24b. REGISTRAR'S SIGNATURE Mabel Griggs	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10018 44
Reg. Dist. No.

10044

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 236 Hilton Street	
3. NAME OF DECEASED (Also: ROBERT First ROBERT (Type or print) H. Middle HANNA Last HANNA)		4. DATE OF DEATH Month October Day 30 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Hanna		14. MOTHER'S MAIDEN NAME Susan Muir	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETES MELLITUS 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) NEPHROSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 24, 1956 to October 30, 1956 , that I last saw the deceased alive , and that death occurred at 3:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/31/56 ACTUAL SIGNATURE Constantine J. Papastrat PHYSICIAN'S NAME (Type) CONSTANTINE J. PAPASTRAT, M.D. VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-2-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Lane ADDRESS Edgar Lane Funeral Home, Church Hill, Md.		24a. REC'D BY REGISTRAR NOV 5 1956	24b. REGISTRAR'S SIGNATURE L. H. Larson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Robert H. Jones		SEX Male		AGE 35	
PLACE OF BIRTH Baltimore, Maryland		DATE OF BIRTH October 1, 1925		TIME OF BIRTH 10:30 A.M.	
OCCUPATION Unknown		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
PLACE OF DEATH Baltimore, Maryland		DATE OF DEATH October 1, 1956		TIME OF DEATH 11:00 A.M.	
SIGNATURE OF PHYSICIAN J. H. Jones, M.D.		SIGNATURE OF REGISTRAR J. H. Jones, M.D.		SIGNATURE OF WITNESS J. H. Jones, M.D.	

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NOV 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10019

10045

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keisterstown</u>				c. LENGTH OF STAY IN 1b <u>13 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Cherry Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BELLE</u> Last <u>HEIGES</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1881</u>	
9. AGE (In years lost birthday) yrs. <u>75</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keisterstown</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Calvin Penseph</u>			
14. MOTHER'S MAIDEN NAME <u>Clara Belle Heller</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mr. Emory Heiges</u> Address <u>Keisterstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>156.1</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August</u> , 19 <u>53</u> to <u>October 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>October 29</u> , 19 <u>56</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.				ADDRESS (Street, city or town, state) <u>Keisterstown Maryland</u> DATE SIGNED <u>Oct 30, 1956</u>			
PHYSICIAN'S NAME (Type) <u>C</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>B-925741778</u>		22d. LOCATION (City, town, or county) (State) <u>B-925741778, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline Sons Keisterstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10 30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Shuee</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

RECEIVED
NOV 1 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10020 33

10046

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>2 years 7 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tng School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rodney</u> Middle <u>Earl</u> Last <u>Hellmig</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Earl Francis Hellmig</u>		14. MOTHER'S MAIDEN NAME <u>Marilyn Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Meredith S. Hale</u>		Address <u>Rosewood State Tng School</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>as Central respiratory failure</u> <u>4700 355x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>organic brain lesions</u> DUE TO (c) <u>Kernicterus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3/15/54</u> , 19 <u>54</u> , to <u>10/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/29</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10/30/56</u>			
ACTUAL SIGNATURE <u>Rich. Lindenberg</u> (Pathologist)		PHYSICIAN'S NAME (Type) <u>Richard Lindenberg, Pathologist</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-31-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. ...</u>		24a. REC'D BY REGISTRAR <u>Nov 2 1956</u>	
ADDRESS <u>8802 Hartford</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elie</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9981

CERTIFICATE OF DEATH

10021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4603 Lincoln Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Daniel Henry</u>				4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fidelity Deposit Co. Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Henry</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Gows</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-4283</u>		17. INFORMANT Address <u>Donald D. Henry 1239 Ten Oaks Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis - 612X</u> DUE TO (b) <u>Myocardial Infarction - a arrhythmia</u> DUE TO (c) <u>Postoperative</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>10 days prior</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 1956</u> to <u>Oct 22, 1956</u> , that I last saw the deceased alive on <u>Oct 1956</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Fredrick J. Barber</u>				M.D. <u>1014 Francis Ave - Balto 27-105</u>			
PHYSICIAN'S NAME (Type) <u>FREDERICK V. BEITLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Kueffner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the registrar, or the general director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10047 CERTIFICATE OF DEATH

10022 31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8343 LIBERTY Rd		d. STREET ADDRESS 8343 LIBERTY Rd	
3. NAME OF DECEASED (Type or print) First ALICE Middle ESTEELLE Last HERSHBERGER		4. DATE OF DEATH Month 10 Day 2 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1875
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAUNDERS		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT SON - WAYNE HERSHBERGER		Address 8343 LIBERTY Rd BALTO. 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION - (c) GENERALIZED ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 15 YEARS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from JANUARY , 19 1875 to OCTOBER 2 , 19 56 , that I last saw the deceased alive on OCTOBER 1 , 19 56 , and that death occurred at 4:33A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin L. Pierpont		ADDRESS (Street, city or town, state) 8204 LIBERTY Rd BALTO. 7, Md.	
DATE SIGNED 10/4/56			
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT MD		8204 LIBERTY Rd - BALTO. 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/56	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.
22d. LOCATION (City, town, or county) Balto., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. J. Vickers & Sons - Balto. 17th		24. REC'D BY REGISTRAR 18 1956	
24b. REGISTRAR'S SIGNATURE Dr. Jm. E. Martin			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1910</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
CITY OF DEATH <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>		DATE OF DEATH <i>Jan 20 1956</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Arteriosclerosis</i>		FINAL CAUSE <i>Hypertension</i>	
DATE OF EXAMINATION <i>Jan 21 1956</i>		PLACE OF EXAMINATION <i>Home</i>		NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		NAME OF SURGEON <i>Dr. J. H. Smith</i>		NAME OF PATHOLOGIST <i>Dr. J. H. Smith</i>		NAME OF FORENSIC EXAMINER <i>Dr. J. H. Smith</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF SURGEON <i>J. H. Smith</i>		SIGNATURE OF PATHOLOGIST <i>J. H. Smith</i>		SIGNATURE OF FORENSIC EXAMINER <i>J. H. Smith</i>		SIGNATURE OF DEATH REGISTRAR <i>J. H. Smith</i>		SIGNATURE OF CLERK <i>J. H. Smith</i>	

BUREAU V. 1

1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use. The funeral director should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
10023 44														
Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 3Y01-4</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHLEHEM STEEL CO., INF.</u>					d. STREET ADDRESS <u>739 S. GRUNDY ST.</u>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE RICHARD HEYMAN</u>					4. DATE OF DEATH Month Day Year <u>10 27 1956</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 19, 1898</u>		9. AGE (in years last birthday) <u>58</u> yrs.						
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICK LAYER</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL CO.</u>					11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>				
13. FATHER'S NAME <u>GEORGE R. HEYMAN.</u>					14. MOTHER'S MAIDEN NAME <u>MARY A. LEHR.</u>					12. CITIZEN OF WHAT COUNTRY?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WORLD WAR I</u>					16. SOCIAL SECURITY NO.					17. INFORMANT Address <u>MAGDALEN HEYMAN SAME.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Dislocation Lumbar Spine</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture Left Tibia & Fibula</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by fork lift truck while in box car at work</u>				
20c. TIME OF INJURY Month, Day, Year Hour <u>3:00</u> p. m. <u>10/27/56</u>					20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>shipyard</u>		20f. (City or town) (County) (State) <u>Bethlehem Steel Co. Balto. Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
ACTUAL SIGNATURE <u>William V. [Signature]</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED				
EXAMINER'S NAME (Type) <u>Charles S. Jailer</u>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 10-31-56</u>					22b. DATE THEREOF					22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM 7401 GERMAN HILL RD., MD.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Jailer</u>					ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>					24a. REC'D BY REGISTRAR DATE <u>Oct 30 1956</u>				
										24b. REGISTRAR'S SIGNATURE <u>Amos L. [Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL REGISTRAR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G206 11-2-56 et

CERTIFICATE OF DEATH

10024

Reg. Dist. No.

10049

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 3829 Park Heights Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Regina Middle Hirshman Last				4. DATE OF DEATH Month October Day 25 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1902	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 3 Days 1 Hours 4 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Isaac Lewkowicz				14. MOTHER'S MAIDEN NAME Fajgla Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 56				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTO.				20g. (County) MD		20h. (State) MD	
21. I certify that I attended the deceased from October 14, 1956 , to October 25, 1956 , that I last saw the deceased alive on Oct. 25 , 19 56 , and that death occurred at 11:55aM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED 10-25-56							
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-26-1956		22c. NAME OF CEMETERY OR CREMATORY ROSEDALE		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Lewis Inc- 2100 Eutan Place				24a. REC'D BY REGISTRAR DATE OCT 29 1956		24b. REGISTRAR'S SIGNATURE G. Harry	

BUREAU V. S.

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the space for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10050

CERTIFICATE OF DEATH

10025

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 MACE AVENUE		d. STREET ADDRESS 204 Mace Avenue	
3. NAME OF DECEASED (Type or print) WILLIAM HORMANN		4. DATE OF DEATH OCTOBER 8, 1956 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 17, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KARL HORMANN		14. MOTHER'S MAIDEN NAME ELIZABETH ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215 03 3781	
17. INFORMANT MRS ELIZABETH HORMANN		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arterio sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. ? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from march, 1956 to 10/8 , 19 56 , that I last saw the deceased alive on 10/1 , 19 56 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Platt		DATE SIGNED 434 Eastern Ave	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.		Cosy, m.d.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 11, 56	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.		24a. REC'D BY REGISTRAR Edith Hurler	
24b. REGISTERAR'S SIGNATURE		DATE 11 1956	

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10026

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> LENGTH OF STAY (in this place) <u>lifetime</u> TOWN <u>Monkton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Irish Ave.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> TOWN <u>Monkton</u> STREET ADDRESS (If rural give location) <u>Irish Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rosalba Cecelia Houck</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 14 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 5 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Meredith Birmingham</u>				14. MOTHER'S MAIDEN NAME <u>Alveta Hawkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>son Howard Houck, Monkton Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardio-vascular</u>						<u>6 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>disease</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1950</u> , to <u>Oct 14 1956</u> , that I last saw the deceased alive on <u>Oct 10 1956</u> , and that death occurred at <u>10A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Eliana B. Sherrill</u>		M.D. <u>Cockeysville Md.</u>		DATE SIGNED <u>10/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10-17-56</u>	NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>		LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>			
24. REC'D BY REGISTRAR DATE <u>10/16/56</u>	REGISTRAR'S SIGNATURE <u>M. Elizabeth Kowach</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Scott Brooks, Sparks, Md.</u>					

10058

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Post Office No.

A. HOUSE NUMBER TO WHICH DEATH OCCURRED

PLACE OF DEATH

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OCT 17 1956

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9973
CERTIFICATE OF DEATH

10027

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6825 Holabird Ave.				d. STREET ADDRESS 6825 Hoslabird Ave.			
3. NAME OF DECEASED (Type or print) LIZZIE P. HUGHES				4. DATE OF DEATH Month October Day 23 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1868		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Porter				14. MOTHER'S MAIDEN NAME Rebecca Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Howard P. Hughes 2 Winona Ave-22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mc. SENTERIC Thrombosis 443X DUE TO Hypertension + A-S-Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arricular Fibrillation						INTERVAL BETWEEN ONSET AND DEATH 30 hrs 15 yrs 1 mo -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Rheumatic Choleliths						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 22, 1956 , to Oct. 23, 1956 , that I last saw the deceased alive on Oct. 23, 1956 , and that death occurred at 6:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. B. Davis				ADDRESS (Street, city or town, state) 6800 Mornington Road Dundalk, Md.			
PHYSICIAN'S NAME (Type) M. B. DAVIS M.D.				DATE SIGNED 10/23/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1956		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				ADDRESS 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE Oct. 24, 1956	
				24b. REGISTRAR'S SIGNATURE Thm. Kelly			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		TREATMENT	
HISTORY OF DEATH		FAMILY HISTORY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. 3

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10028

Reg. Dist. No.

9982

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3630 Washington Blvd</i>		d. STREET ADDRESS <i>3630 Wash Blvd</i>	
3. NAME OF DECEASED (Type or print) <i>Adelle</i> First <i>Hendley</i> Middle Last		4. DATE OF DEATH <i>Oct 19</i> Month Day Year <i>19 56</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jul 3 1899</i>
9. AGE (In years last birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Acc Md</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Lobias Stewart</i>		14. MOTHER'S MAIDEN NAME <i>Louise Cook</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Adelle Hendley</i> Address <i>3630 Wash Blvd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> <i>443X</i> DUE TO (b) <i>Hypertension Cordis Vasculare</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Geo S M Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>GEO S M KIEFFER</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 22 56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Lukes Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Harmon Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Miss Kate R. Williams</i>		ADDRESS <i>3229 N. Schomdt St</i>	
24a. REC'D BY REGISTRAR <i>Dr. Geo M. Kieffer</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Geo M. Kieffer</i>	
DATE <i>Oct 22 1956</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the coroner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. If the body is to be buried, cremated, or removed, file pages 1 and 2 with the registrar permit. File pages 1 and 2 with the registrar permit.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

9561 82 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10029

10052

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 28 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent, 1001 W. Joppa Rd.				d. STREET ADDRESS 1001 West Joppa Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Providencia (Hurley)				4. DATE OF DEATH Month Day Year DECEASED 10/9/56 19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun				10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (State or foreign country) County Cork, Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Hurley				14. MOTHER'S MAIDEN NAME Catherine O'Leary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Convent Records, 1001 W. Joppa Road, Towson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Renal DUE TO Vascular Disease (c) 104 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 104						INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 1949 to October 9, 1956 , that I last saw the deceased alive on October 8, 1956 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 7501 York Road		DATE SIGNED Oct. 10, 1956	
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell				7501 York Road			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery,		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemmon				ADDRESS 4611 Park Heights Ave.		24a. REC'D BY REGISTRAR DATE OCT 11 1956	
				24b. REGISTRAR'S SIGNATURE Malcolm Gray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Henry		Male		28 years	
Place of Birth		Date of Birth		Date of Death	
London, England		1911		1939	
Cause of Death		Disease		Organ	
Heart Disease		Coronary Artery Sclerosis		Heart	
Duration of Illness		Date of Admission to Hospital		Date of Discharge	
3 weeks		10/1/39		10/10/39	
Place of Death		Date of Death		Time of Death	
Hospital		10/10/39		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 11 1956

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OCT 10 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10030

10053

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 929 Saint Agnes Lane		d. STREET ADDRESS 929 Saint Agnes Lane	
3. NAME OF DECEASED (Type or print) First Virginia Middle M. Last Immler		4. DATE OF DEATH Month Oct. Day 26 Year 1956	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1918
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Little		14. MOTHER'S MAIDEN NAME Josephine Iacovetti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George A. Immler, 929 St. Agnes Lane, Catonsv.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Left Breast with 170X DUE TO Generalized Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10/55 , 19____, to 10/26/56 , 19____, that I last saw the deceased alive on 10/26/56 , 19____, and that death occurred on 8.10 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Joseph G. Laukaitis M.D. PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS, M.D. 679 WASHINGTON BLVD. BALTO 30-MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30/56	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke		24a. REC'D. BY REGISTRAR Oct. 30, 1956	
ADDRESS 4101 Edmondson		24b. REGISTRAR'S SIGNATURE V. E. Harry	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY		POLITICAL PARTY		MILITARY SERVICE	
SHOOTING		SUICIDE		FARMER		HIGH SCHOOL		METHODIST		MEMBER		DEMOCRAT		ARMY	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
FATHER'S NAME		MOTHER'S NAME		FATHER'S NAME		MOTHER'S NAME		FATHER'S NAME		MOTHER'S NAME		FATHER'S NAME		MOTHER'S NAME	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
OCT 31 1956
BUREAU V. 4

Joseph's Banknote

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10031

10054

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 28yr7mt19dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George RAYMOND Jackson		4. DATE OF DEATH Month Day Year October 7 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James W. Jackson		14. MOTHER'S MAIDEN NAME Jane Algire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure due to 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pulmonary - hypertensive DUE TO (c) cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 2, 1956 , to 10-7-56 , that I last saw the deceased alive on 10-7-56 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		DATE SIGNED Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY ARCADIA LUTHERN CEM.		22d. LOCATION (City, town, or county) (State) ARCADIA, BALTO. CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns, Son		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR DATE OCT 9 1956		24b. REGISTRAR'S SIGNATURE T. E. Harris	

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. J. J. J. J.		2. SEX M		3. AGE 45		4. DATE OF BIRTH 10-10-1910		5. PLACE OF BIRTH MASSACHUSETTS	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE MASSACHUSETTS		10. DATE OF DEATH 10-10-1956	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH 10-10-1956		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF DECEASED J. J. J. J. J.	
16. SIGNATURE OF WITNESS J. J. J. J. J.		17. SIGNATURE OF PHYSICIAN J. J. J. J. J.		18. SIGNATURE OF CLERK J. J. J. J. J.		19. SIGNATURE OF REGISTRAR J. J. J. J. J.		20. SIGNATURE OF DECEASED J. J. J. J. J.	

RECEIVED
OCT 9 1956
BUREAU V. 3

10055

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7531 Durwood Rd</u>				d. STREET ADDRESS <u>7531 Durwood Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Minnie Delmar Joiner</u>				4. DATE OF DEATH <u>Oct. 13, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1886</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13. FATHER'S NAME <u>Benjamin Sewell</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-05-9139B</u>		17. INFORMANT <u>Mr. John Joiner</u> Address <u>7531 Durwood Rd</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C-V. Disease</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>OCT 17 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly, Jr.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. The registrar permits burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
OCT 17 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1533 Knecht Ave		d. STREET ADDRESS 1533 Knecht Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth A. Kahmer		4. DATE OF DEATH Month Day Year Oct. 4, 1956 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Conrad Plock		14. MOTHER'S MAIDEN NAME Bertha	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. no ne	
17. INFORMANT Louis V. Kahmer, 1533 Knecht Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.D. (c) unknown.		INTERVAL BETWEEN ONSET AND DEATH instantaneous	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-46 , 19____, to 10-4-56 , 19____, that I last saw the deceased alive on 9-25-56 , 19____, and that death occurred at 4:00 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Nathan Racusin		ADDRESS (Street, city or town, state) DATE SIGNED 206 S. Gilmer St. Balto 23 Md 10-5-56	
PHYSICIAN'S NAME (Type) NATHAN RACUSIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-8-56	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave		24a. REC'D BY REGISTRAR 0078 DATE 1956	
		24b. REGISTRAR'S SIGNATURE <i>Lin E. M. Jeffery</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL REGISTRAR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar. The registrar may be the funeral director, or the registrar may be the funeral director, or the registrar may be the funeral director.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		Jan 1, 1956	
Age		Sex	
45		Male	
Race		Color	
White		White	
Place of Birth		Usual Residence	
Baltimore, Md.		Baltimore, Md.	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Heart Disease	
Duration of Illness		Period of Incubation	
10 Days		None	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Signature		Date of Signature	
Jan 1, 1956		Jan 1, 1956	

BUREAU V. 2

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10035

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10057

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS Woodstock College	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodstock College		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jerome T. Kane Sr.		4. DATE OF DEATH Month Day Year October 31 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist at Woodstock College		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Bartholme, Kane		14. MOTHER'S MAIDEN NAME Mary Nallen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-03-8347	
17. INFORMANT Jerome T. Kane Jr.		Address 1506 North Rolling Road, Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 783.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH unknown
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) none
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1956	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong, Baltimore, Md.		24a. RECEIVED BY REGISTRAR DATE Nov 5, 1956	
		24b. REGISTRAR'S SIGNATURE D. W. Ham. E. M. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

MANUAL OF STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 10

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John T. Lane Sr.		Male		65		White		1956		Baltimore, Md.	
Residence at Time of Death		Occupation		Cause of Death		Manner of Death		Medical History		Remarks	
1500-15-0000, Jerome T. Lane Dr., Baltimore, Md.		Retired		1500-15-0000, Jerome T. Lane Dr., Baltimore, Md.		Natural		1500-15-0000, Jerome T. Lane Dr., Baltimore, Md.		1500-15-0000, Jerome T. Lane Dr., Baltimore, Md.	
Physician		Hospital		Coroner		Medical Examiner		Pathologist		Burial	
Mary Keller		Woodstock College		Woodstock College		Woodstock College		Woodstock College		Woodstock College	
Signature of Physician		Signature of Hospital		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Burial	
Date		Time		Place		Cause		Manner		Remarks	
1956		11:00 AM		1500-15-0000, Jerome T. Lane Dr., Baltimore, Md.		Natural		Natural		1500-15-0000, Jerome T. Lane Dr., Baltimore, Md.	

BUREAU V. 2

NOV 5 1956

RECEIVED

0. Howard Brown, Baltimore, Md.
Nov. 5, 1956
2807 W. 10th Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10058

CERTIFICATE OF DEATH

10036 30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Mt. Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 42 yrs. 3 mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) MARY A. KEIDEL				4. DATE OF DEATH 10-7-1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY housewife		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME George Frazier				14. MOTHER'S MAIDEN NAME Mary Lauren			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Agnes Frazier Fink's burg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X carcinoma pancreas with liver metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) liver metastasis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-1- , 19 54 , to 10-7- , 19 56 that I last saw the deceased alive on 10-7- , 19 56 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David Edwards MD				ADDRESS (Street, city or town, state) DAVID E. EDWARDS 10-7-56			
PHYSICIAN'S NAME (Type) DAVID E. EDWARDS				DATE SIGNED Spring Grove Hospital, Catonsville			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tacknow				ADDRESS 1400 N. E. St. Baltimore Md.		24a. REC'D BY REGISTRAR 8 1956	
				24b. REGISTRAR'S SIGNATURE T. E. Harry			

RECEIVED

10059

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
 2. SEX: ☐ MALE ☐ FEMALE
 3. AGE: _____
 4. DATE OF BIRTH: _____
 5. PLACE OF BIRTH: _____
 6. OCCUPATION: _____
 7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
 8. PREVIOUS ILLNESS: _____
 9. CAUSE OF DEATH: _____
 10. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE
 11. SIGNATURE OF EXAMINER: _____
 12. DATE OF EXAMINATION: _____

RECEIVED
 OCT 30 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, who should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10038

10060

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2525 Windsor Road</u>		d. STREET ADDRESS <u>2525 Windsor Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leona Grace Kersey</u>		4. DATE OF DEATH Month Day Year <u>10 16 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 7 1878</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas E. Grace</u>		14. MOTHER'S MAIDEN NAME <u>Susan R. Preston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Raymond E. Grace</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/14</u> , 19 <u>54</u> to <u>10/16/56</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>56</u> , and that death occurred at <u>5:00 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Nathan Janney</u> M.D.			
PHYSICIAN'S NAME (Type) <u>7101 Harford Rd. Balto., Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 19, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Hambleton Harrison</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 22 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Marten</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10039

10061

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 86 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JEREMIAH Middle (NMI) Last KIAH				4. DATE OF DEATH Month OCTOBER Day 10 Year 1956			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-92	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY JANITOR, PLASTIC		11. BIRTHPLACE (State or foreign country) CAMBRIDGE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN KIAH			
14. MOTHER'S MAIDEN NAME JULIA MYSTER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1			
16. SOCIAL SECURITY NO. 218-10-2887				17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, RIGHT LUNG WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTIMORE				20g. (County) MARYLAND		20h. (State) MARYLAND	
21. I certify that I attended the deceased from July 16 , 19 56 , to Oct. 10 , 19 56 , and that death occurred at 6:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/11/56							
ACTUAL SIGNATURE Irving Freeman				M.D. IRVING FREEMAN, M.D.			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/15/56		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES R LAW MORTUARY 802-04 MADISON AVE BALTO MD				24a. REC'D BY REGISTRAR 10/15/56		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

10084

DATE OF DEATH		PLACE OF DEATH	
OCT 17 1956		BALTIMORE, MARYLAND	
DECEASED'S NAME		DECEASED'S SEX	
JOHN J. JONES		MALE	
DECEASED'S AGE		DECEASED'S RACE	
45		WHITE	
DECEASED'S OCCUPATION		DECEASED'S MARITAL STATUS	
LABORER		MARRIED	
DECEASED'S BIRTH DATE		DECEASED'S BIRTH PLACE	
JAN 15 1911		BALTIMORE, MARYLAND	
DECEASED'S MOTHER'S NAME		DECEASED'S FATHER'S NAME	
MARY J. JONES		JOHN J. JONES	
DECEASED'S PRESENT ADDRESS		DECEASED'S LAST ADDRESS	
1234 E. MAIN ST., BALTIMORE, MD.		1234 E. MAIN ST., BALTIMORE, MD.	
DECEASED'S PRESENT PHONE		DECEASED'S LAST PHONE	
BAL 1-2345		BAL 1-2345	
DECEASED'S PRESENT RELIGION		DECEASED'S LAST RELIGION	
CATHOLIC		CATHOLIC	
DECEASED'S PRESENT EDUCATION		DECEASED'S LAST EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
DECEASED'S PRESENT EMPLOYER		DECEASED'S LAST EMPLOYER	
BALTIMORE STEEL CO.		BALTIMORE STEEL CO.	
DECEASED'S PRESENT SOCIAL SECURITY		DECEASED'S LAST SOCIAL SECURITY	
1-234567890		1-234567890	
DECEASED'S PRESENT MEDICAL INSURANCE		DECEASED'S LAST MEDICAL INSURANCE	
BALTIMORE HEALTH PLAN		BALTIMORE HEALTH PLAN	
DECEASED'S PRESENT LIFE INSURANCE		DECEASED'S LAST LIFE INSURANCE	
BALTIMORE LIFE CO.		BALTIMORE LIFE CO.	
DECEASED'S PRESENT AUTO INSURANCE		DECEASED'S LAST AUTO INSURANCE	
BALTIMORE AUTO CO.		BALTIMORE AUTO CO.	
DECEASED'S PRESENT HOMEOWNERS INSURANCE		DECEASED'S LAST HOMEOWNERS INSURANCE	
BALTIMORE HOMEOWNERS CO.		BALTIMORE HOMEOWNERS CO.	
DECEASED'S PRESENT FIRE INSURANCE		DECEASED'S LAST FIRE INSURANCE	
BALTIMORE FIRE CO.		BALTIMORE FIRE CO.	
DECEASED'S PRESENT FLOOD INSURANCE		DECEASED'S LAST FLOOD INSURANCE	
BALTIMORE FLOOD CO.		BALTIMORE FLOOD CO.	
DECEASED'S PRESENT TERRORISM INSURANCE		DECEASED'S LAST TERRORISM INSURANCE	
BALTIMORE TERRORISM CO.		BALTIMORE TERRORISM CO.	
DECEASED'S PRESENT OTHER INSURANCE		DECEASED'S LAST OTHER INSURANCE	
BALTIMORE OTHER CO.		BALTIMORE OTHER CO.	
DECEASED'S PRESENT ESTATE PLANNING		DECEASED'S LAST ESTATE PLANNING	
BALTIMORE ESTATE PLANNING CO.		BALTIMORE ESTATE PLANNING CO.	
DECEASED'S PRESENT PROBATE		DECEASED'S LAST PROBATE	
BALTIMORE PROBATE CO.		BALTIMORE PROBATE CO.	
DECEASED'S PRESENT TRUST		DECEASED'S LAST TRUST	
BALTIMORE TRUST CO.		BALTIMORE TRUST CO.	
DECEASED'S PRESENT WILL		DECEASED'S LAST WILL	
BALTIMORE WILL CO.		BALTIMORE WILL CO.	
DECEASED'S PRESENT ESTATE TAX		DECEASED'S LAST ESTATE TAX	
BALTIMORE ESTATE TAX CO.		BALTIMORE ESTATE TAX CO.	
DECEASED'S PRESENT GIFT TAX		DECEASED'S LAST GIFT TAX	
BALTIMORE GIFT TAX CO.		BALTIMORE GIFT TAX CO.	
DECEASED'S PRESENT INCOME TAX		DECEASED'S LAST INCOME TAX	
BALTIMORE INCOME TAX CO.		BALTIMORE INCOME TAX CO.	
DECEASED'S PRESENT CAPITAL GAINS TAX		DECEASED'S LAST CAPITAL GAINS TAX	
BALTIMORE CAPITAL GAINS TAX CO.		BALTIMORE CAPITAL GAINS TAX CO.	
DECEASED'S PRESENT ESTATE PLANNING		DECEASED'S LAST ESTATE PLANNING	
BALTIMORE ESTATE PLANNING CO.		BALTIMORE ESTATE PLANNING CO.	
DECEASED'S PRESENT PROBATE		DECEASED'S LAST PROBATE	
BALTIMORE PROBATE CO.		BALTIMORE PROBATE CO.	
DECEASED'S PRESENT TRUST		DECEASED'S LAST TRUST	
BALTIMORE TRUST CO.		BALTIMORE TRUST CO.	
DECEASED'S PRESENT WILL		DECEASED'S LAST WILL	
BALTIMORE WILL CO.		BALTIMORE WILL CO.	
DECEASED'S PRESENT ESTATE TAX		DECEASED'S LAST ESTATE TAX	
BALTIMORE ESTATE TAX CO.		BALTIMORE ESTATE TAX CO.	
DECEASED'S PRESENT GIFT TAX		DECEASED'S LAST GIFT TAX	
BALTIMORE GIFT TAX CO.		BALTIMORE GIFT TAX CO.	
DECEASED'S PRESENT INCOME TAX		DECEASED'S LAST INCOME TAX	
BALTIMORE INCOME TAX CO.		BALTIMORE INCOME TAX CO.	
DECEASED'S PRESENT CAPITAL GAINS TAX		DECEASED'S LAST CAPITAL GAINS TAX	
BALTIMORE CAPITAL GAINS TAX CO.		BALTIMORE CAPITAL GAINS TAX CO.	

BUREAU V. 2

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10040

10062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 MIDDLE RIVER				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00				d. STREET ADDRESS 83X-3			
3. NAME OF DECEASED (Type or print) First BEULAH Middle KILLMON Last KILLMON				4. DATE OF DEATH Month OCTOBER Day 12 Year 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 15, 1893		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) PARKSLEY, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WILLIAM ONLEY				14. MOTHER'S MAIDEN NAME HENRIETTA NORTHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MR. NOAH KILLOM PARKSLEY, VIRGINIA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1956 to Oct. 12, 1956 , that I last saw the deceased alive on 10-4-1956 , and that death occurred at 9 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 805 FUSELAGE AVE, MIDDLE RIVER, MD. DATE SIGNED							
ACTUAL SIGNATURE Marvin J. Rombro M.D.				PHYSICIAN'S NAME (Type) MARVIN J. ROMBRO.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 10-12-56		22c. NAME OF CEMETERY OR CREMATORY PARKSLEY BAPTIST		22d. LOCATION (City, town, or county) (State) PARKSLEY, VIRGINIA.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jickner and Sons, Balto. 17. Md.				24a. REC'D BY REGISTRAR ACT 15 1956		24b. REGISTRAR'S SIGNATURE Edith Hurley	

[illegible]

RECEIVED
OCT 15 1956
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10041

10063

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5743 Edmondson Ave. Ridgeway Manor Nurs. Ho.				d. STREET ADDRESS 3612 Woodbine Ave.			
3. NAME OF DECEASED (Type or print) First JACOB Middle KING Last KING				4. DATE OF DEATH Month Oct. Day 3 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 1, 1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR: Months 3 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob King				14. MOTHER'S MAIDEN NAME Jeannette (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-03-3540		17. INFORMANT Mr. Charles Stallings-3612 Woodbine Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Insufficiency of Age DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10-2 , 19 56 , to 10-3 , 19 56 , that I last saw the deceased alive on 10-2 , 19 56 , and that death occurred at 9:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Thomas G. Abbott				ADDRESS (Street, city or town, state) 4509 Liberty Heights Ave. BALTO MD		DATE SIGNED 10-5-56	
PHYSICIAN'S NAME (Type) DR THOMAS G ABBOTT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Pickens & Sons - Balto. 17th St.				24a. REC'D BY REGISTRAR 10/6/56		24b. REGISTRAR'S SIGNATURE R. W. E. Harvey	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

10042

2411 N. Charles Street, Baltimore

10064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND Md		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa</u>		STREET ADDRESS (If rural, give location) <u>Ambassador Apts</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Agnes</u>	(Middle) <u>G.</u>	(Last) <u>Kirby</u>
4. DATE OF DEATH	(Month) <u>Oct.</u>	(Day) <u>30</u>	(Year) <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 11, 1882</u>
9. AGE last birthday <u>74</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>Baltimore, Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph H. Kirby</u>		14. MOTHER'S MAIDEN NAME <u>Mary FitzPatrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mr. Raymond A. Kirby 1927 Park Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pneumonia, Anger's Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

2-3 daysAntecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Cerebral vascular accident, Hypertension, arterial sclerosis,Gradual(c) Myocarditis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1945, to Oct 30, 1956, that I last saw the deceasedalive on Oct 30, 1956, and that death occurred at 8:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

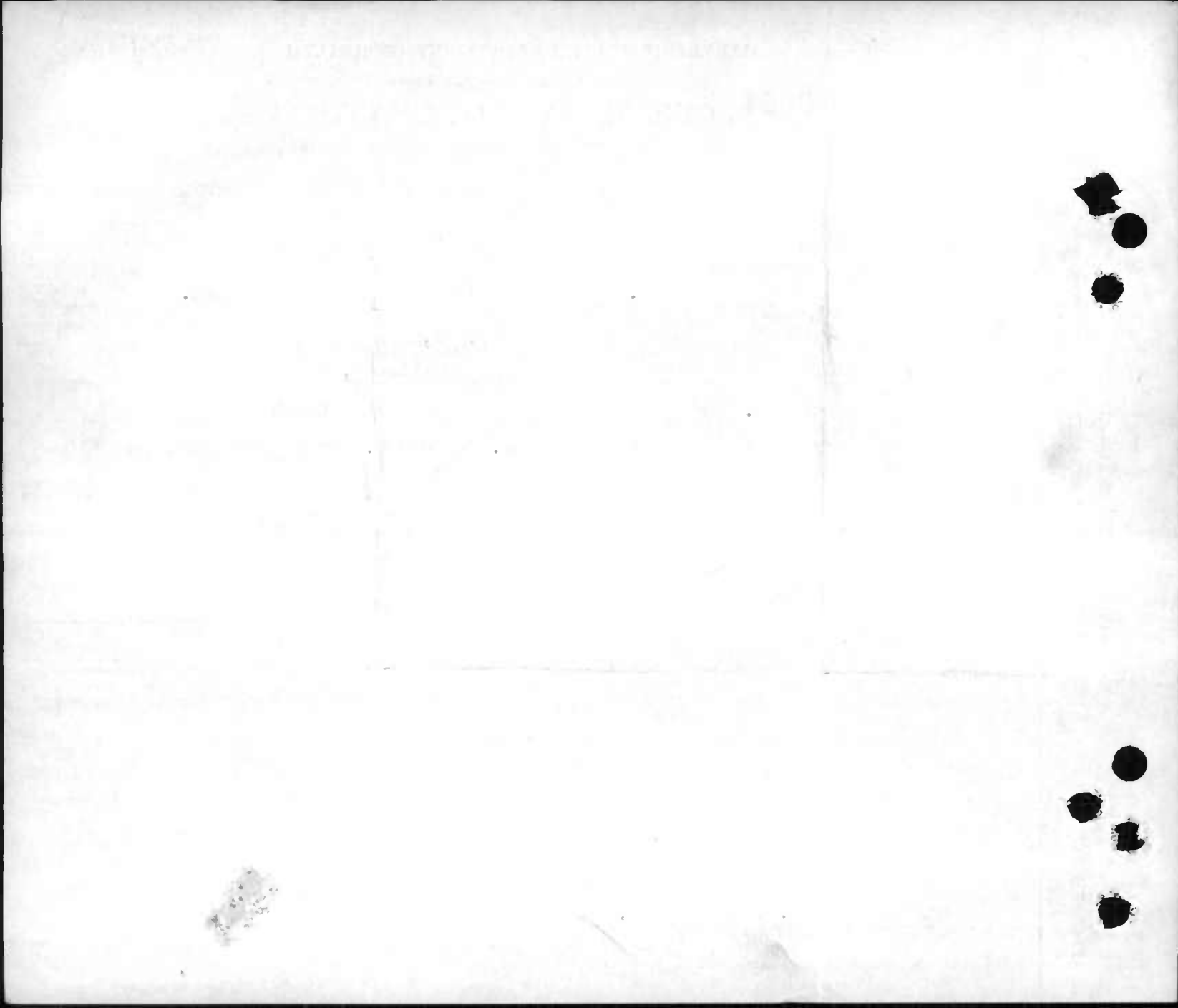
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Nov. 2, 1956</u>	<u>St. Mary's Govans</u>	<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
		<u>H. W. Mearns & Son</u>	<u>805 N Calvert St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9974 CERTIFICATE OF DEATH

10043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>5</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8219 DOGWOOD DRIVE</u>				d. STREET ADDRESS <u>#1</u>											
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>FRANK</u> Middle <u>KLAUS</u> Last <u>SR.</u>				4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>56</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JAN. 8, 1881</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FLOOR COVERING</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>									
13. FATHER'S NAME <u>JACOB KLAUS</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. KELLER</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>196-10-3166</u>		17. INFORMANT <u>MILDRED E. LOGAN</u> Address <u>311 BAYSIDE DR. DUNDALK 22</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Left hydronephrosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1953</u> <u>1954</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>OCT 28, 1953</u> , to <u>OCT 19, 1956</u> , that I last saw the deceased alive on <u>OCT 19, 1956</u> , and that death occurred on <u>OCT 19, 1956</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Eugene F Nery</u> M.D.				ADDRESS (Street, city or town, state) <u>7001 Mornington Rd. Dundalk, Md</u>											
PHYSICIAN'S NAME (Type) <u>Eugene F Nery M.D.</u>				DATE SIGNED											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S</u>		22d. LOCATION (City, town, or county) (State) <u>LANCASTER, PENNA</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Carl Rodley, Dundalk, Md</u>				24a. REC'D BY REGISTRAR <u>OCT 22 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Walter J. Kelly</u>									

RECEIVED

OCT 22 1956

BUREAU V. S.

EXHIBIT 5 MAY 1956

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

10065

CERTIFICATE OF DEATH

10044

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pleasant Grove</u>				e. STREET ADDRESS <u>Pleasant Grove</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>ANN</u> Last <u>KORMAN</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 24, 1875</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Brathburn</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Duce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Bessie Korman</u> Address <u>Reisterstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>H22.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>August 15, 1956</u> to <u>Oct 25, 1956</u> , that I last saw the deceased alive on <u>October 22, 1956</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>		DATE SIGNED <u>10.25.56</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				ADDRESS <u>Hampstead Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 27-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Lipton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>DATE 10-26</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B Elmer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, or the registrar, should detach page 3 and take it to the funeral home for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten text]		SEX [Faint handwritten text]		AGE [Faint handwritten text]	
PLACE OF BIRTH [Faint handwritten text]		DATE OF BIRTH [Faint handwritten text]		PLACE OF DEATH [Faint handwritten text]	
OCCUPATION [Faint handwritten text]		CAUSE OF DEATH [Faint handwritten text]		MANNER OF DEATH [Faint handwritten text]	
TIME OF DEATH [Faint handwritten text]		PLACE OF INTERMENT [Faint handwritten text]		NAME OF FUNERAL HOME [Faint handwritten text]	
SIGNATURE OF DECEASED [Faint handwritten text]		SIGNATURE OF WITNESS [Faint handwritten text]		SIGNATURE OF PHYSICIAN [Faint handwritten text]	
SIGNATURE OF CLERK [Faint handwritten text]		SIGNATURE OF REGISTRAR [Faint handwritten text]		SIGNATURE OF JUDGE [Faint handwritten text]	

BUREAU V. S.

OCT 30 1956

RECEIVED

BUREAU V. 8

101 10 1956

RECEIVED

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10046

Reg. Dist. No. 37

10066

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MD</u>		COUNTY <u>Easton</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>COCKEYSVILLE</u>		<u>17 YEARS</u>		TOWN <u>EASTON</u>		<u>20-40-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>HARVEY</u> (Middle) <u>LEONARD</u> (Last)				(Month) <u>10</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>WIDOWED</u>	<u>9/28/1873</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>DENTIST</u>				<u>TALBOT COUNTY, MD</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JONATHAN HADAWAY LEONARD</u>				<u>ANNA MATILDA NEWMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>Frank L. Smith Jr. Cockeysville, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardio Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/28</u> , 19 <u>47</u> , to <u>10/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Kees</u>		M.D. <u>Cockeysville, Md.</u>		DATE SIGNED <u>10/1/56</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-4-56</u>		<u>SPRING HILL CEM.</u>		<u>EASTON, MARYLAND</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>OCT 4 1956</u>		<u>Frank Smith</u>		<u>William Cook, Jr.</u>		<u>1217 ST. PAUL ST.</u>	

CERTIFICATE OF DEATH

Each Day No.

1. HEALTH RESIDENCE PLACE OF DECEASED

2. PLACE OF DEATH

3. MARYLAND

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF BURIAL

11. NAME OF FUNERAL HOME

12. NAME OF MINISTER

13. NAME OF CHURCH

14. NAME OF CEMETERY

15. NAME OF INTERVIEWER

16. NAME OF WITNESS

17. NAME OF SIGNER

18. NAME OF REGISTRAR

19. NAME OF CLERK

20. NAME OF ASSISTANT

21. NAME OF ATTORNEY

22. NAME OF JUDGE

23. NAME OF SHERIFF

24. NAME OF CONSTABLE

25. NAME OF JURY

26. NAME OF GRAND JURY

27. NAME OF DISTRICT CLERK

28. NAME OF COUNTY CLERK

29. NAME OF CITY CLERK

30. NAME OF TOWN CLERK

31. NAME OF VILLAGE CLERK

32. NAME OF POST OFFICE CLERK

33. NAME OF SCHOOL CLERK

34. NAME OF CHURCH CLERK

BUREAU V. 2

OCT 9 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10047

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

10067

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mill Dam Road near Seminary Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>J.</u> Last <u>LEONARD</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15, 1915</u>	
9. AGE (In years, last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Layout Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bartlett -Hayward</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James A. Leonard</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Bohnet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-07-3965</u>		17. INFORMANT <u>Family records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. [Signature]</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) _____				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons,</u>				ADDRESS <u>Towson, Maryland</u>		24a. REC'D BY REGISTRAR <u>10/29/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mark C. Gray</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. (Pages 5 may be retained for your file.)

...MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 30 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled with the name of the funeral home to which the body is being taken. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 3 and 4, and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9934

CERTIFICATE OF DEATH

10048
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 732 Beechfield Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Anna Lewis Middle Last		4. DATE OF DEATH Month October 10, Day 19 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis Deering		14. MOTHER'S MAIDEN NAME Barbara S. Limmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-2411	
17. INFORMANT Howard W. Lewis		Address 732 Beechfield Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1.2 hours 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1955 to Oct 10, 1956 , that I last saw the deceased alive on Oct 10, 1956 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4001 Wilkens Ave Baltimore, Md. DATE SIGNED 10-11-56			
ACTUAL SIGNATURE I. Earl Pass M.D.		PHYSICIAN'S NAME (Type) I. EARL PASS, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/13/56	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard M. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR DATE OCT 15 1956		24b. REGISTRAR'S SIGNATURE Dr. Earl M. Luff	

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL PUBLIC: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10049

10068

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 3921 Norfolk Avenue			
3. NAME OF DECEASED (Type or print) JAKE First Middle Last M. LIBERMAN				4. DATE OF DEATH October 22 1956 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Clothing Business		11. BIRTHPLACE (State or foreign country) Ponevez, Russia	
13. FATHER'S NAME Harry Liberman				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Unknown			
				17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Fort Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 8 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 16, 1956 to October 22, 1956 and that death occurred at 1:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 10/22/56							
ACTUAL SIGNATURE C. J. Papastrat MD				PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-56		22c. NAME OF CEMETERY OR CREMATORY Hebrew Cemetery - Windsor Mill Rd		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc., 2100 Eutaw Pl., Balto., Md.				24. REC'D BY REGISTRAR 01 24 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Harber	

RECEIVED

OCT 24 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 1956	
CERTIFICATE OF DEATH	
10028	
PLACE TO BE FILLED BY THE REGISTRAR	
1. Name of Deceased: John Henry	
2. Sex: Male	
3. Age: 8 Days	
4. Date of Birth: June 25, 1952	
5. Date of Death: October 10, 1956	
6. Place of Birth: Baltimore, Maryland	
7. Place of Death: Baltimore, Maryland	
8. Cause of Death: Infantile Mortality	
9. Manner of Death: Natural	
10. Signature of Registrar: John Henry	
11. Signature of Physician: John Henry	
12. Signature of Coroner: John Henry	
13. Signature of Burial Director: John Henry	
14. Signature of Funeral Home: John Henry	
15. Signature of Cemetery: John Henry	
16. Signature of Burial: John Henry	
17. Signature of Interment: John Henry	
18. Signature of Burial: John Henry	
19. Signature of Interment: John Henry	
20. Signature of Burial: John Henry	
21. Signature of Interment: John Henry	
22. Signature of Burial: John Henry	
23. Signature of Interment: John Henry	
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97. Signature of Interment: John Henry	
98. Signature of Burial: John Henry	
99. Signature of Interment: John Henry	
100. Signature of Burial: John Henry	

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10069 **CERTIFICATE OF DEATH**

10050

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 1mth5dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle W. Last Link				4. DATE OF DEATH Month October Day 18 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1884		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Link				14. MOTHER'S MAIDEN NAME Lizzie Lacombe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Myocardial infarction Coronary and generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 mth. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SPRING GROVE STATE HOSPITAL	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 13, 19 56 , to October 18, 19 56 , that I last saw the deceased alive on Oct. 18, 19 56 , and that death occurred at 8:30 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles S. Ward</i>				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 10-18-56			
PHYSICIAN'S NAME (Type) Charles S. Ward, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Pickner & Sons - Balto.</i>				24a. REC'D BY REGISTRAR 17		24b. REGISTRAR'S SIGNATURE <i>F. C. Harvey</i>	

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
HOME		MARRIED	
HOSPITAL		SINGLE	
OTHER		WIDOWED	
DATE OF DEATH		DATE OF MARRIAGE	
OCT 22 1956		OCT 22 1956	
TIME OF DEATH		TIME OF MARRIAGE	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
OCT 22 1956		OCT 22 1956	
TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM	
PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME	
HOSPITAL		HOSPITAL	
OTHER		OTHER	
DATE OF DEATH		DATE OF DEATH	
OCT 22 1956		OCT 22 1956	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
OCT 22 1956		OCT 22 1956	
TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM	

BUREAU V. S.

OCT 22 1956

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
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BUREAU V. S.

9561 21 100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10052

10071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood</u>	
TOWN <u>5113 Kenwood Ave</u>		TOWN <u>5113 Kenwood Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Joseph (Giuseppe) Mangano</u>		4. DATE OF DEATH <u>Oct 28 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 16 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cops</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mangano</u>		14. MOTHER'S MAIDEN NAME <u>Angelina Parisi</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>618-32-1011</u>	
17. INFORMANT AND ADDRESS <u>Angelina Mangano 5113 Kenwood</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443X Immediate cause (a) <u>Hypertensive Arteriosclerotic C.V.D.</u>		<u>10 yrs</u>
Antecedent cause(s) (b) _____		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1959, to 10/28, 1956, that I last saw the deceased alive on 10/25, 1956, and that death occurred at 2:50 p.m., from the causes and on the date stated above.

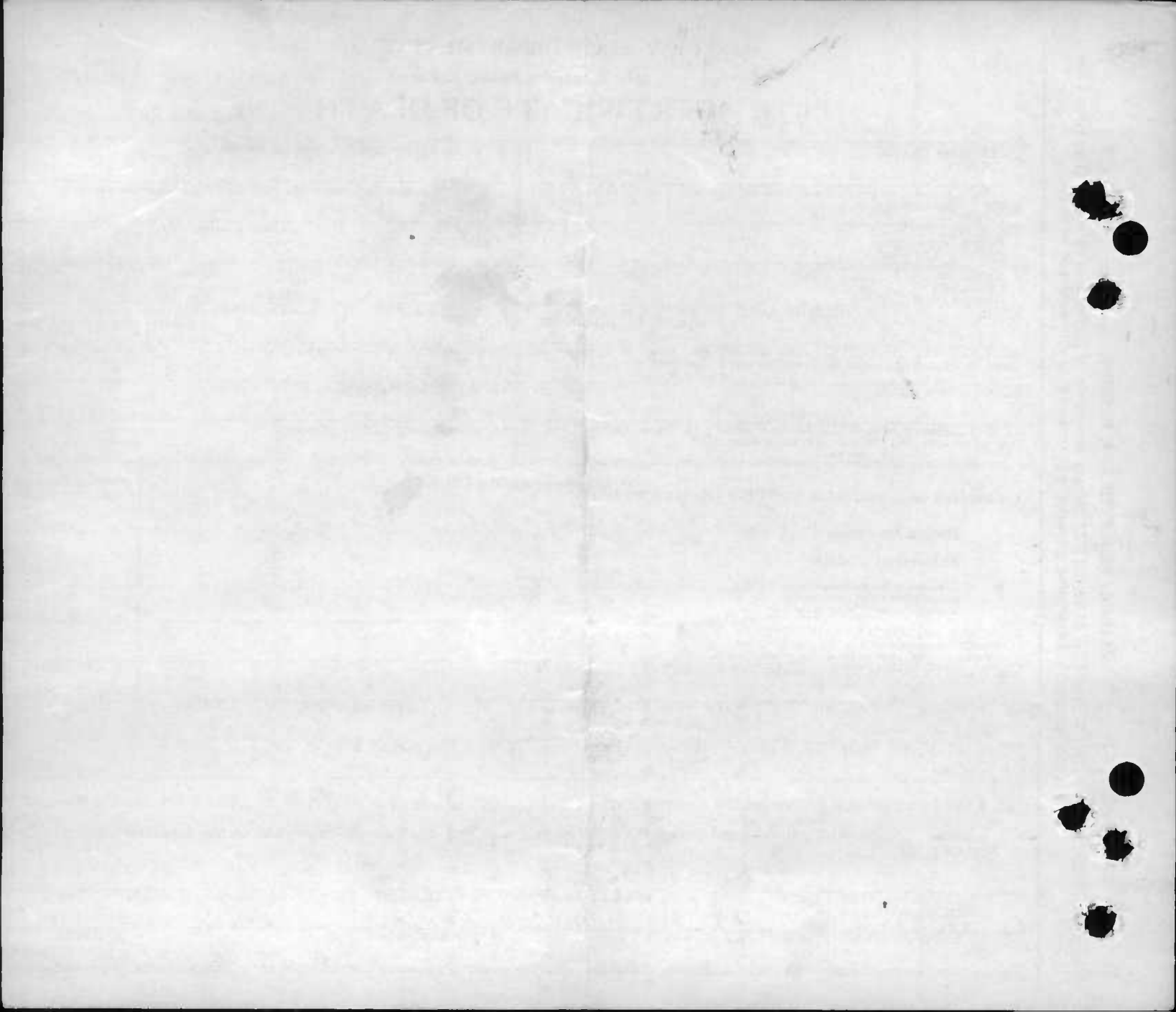
SIGNATURE D. J. Pettaglia MD ADDRESS 5829 Belair Rd DATE SIGNED 10/29/56

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>OCT 31 1956</u>	NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>	LOCATION (City, town, or county) (State) <u>TAYLOR AVE MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>Lappil Pro</u>	ADDRESS <u>7110 BELAIR RD</u>

MARGIN RESERVED FOR BINDING

VS. A

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10072

CERTIFICATE OF DEATH

Reg. Dist. No.

10053

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr11mt25dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Altamont Hotel - Eutaw & Lanvale Sts	
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Marshall		4. DATE OF DEATH Month October Day 29 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James F. Johnson		14. MOTHER'S MAIDEN NAME Sally Elizabeth Tull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) Dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Debility - Decubital sores			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 3, 1956 to Oct. 29, 1956 , that I last saw the deceased alive on Oct. 29, 1956 , and that death occurred at 8:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 10-29-56			
ACTUAL SIGNATURE Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Episcopal Cem. Pocomoke City, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto 17 Md		24. REC'D BY REGISTRAR DATE Oct. 30, 1956	
24b. REGISTRAR'S SIGNATURE T. E. Harvey			

BUREAU

OCT 31 1956

REC'D - MAY 23 1964

10073

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2511 Hillcrest Avenue</i>				d. STREET ADDRESS <i>2511 Hillcrest Avenue</i>			
3. NAME OF DECEASED (Type or print) <i>Mr. Fritz Adolf Karl Martin</i>				4. DATE OF DEATH <i>October 19th 1956</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 29, 1889</i>	9. AGE (In years last birthday) <i>67</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brick Mason</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Berlin, Germany</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Adolf Martin</i>			
14. MOTHER'S MAIDEN NAME <i>Johanna Cuba</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Mrs. Erna E. Martin, 2511 Hillcrest Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic C.V.D.</i> (b) <i>Arteriosclerotic C.V.D.</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1955</i> to <i>Oct. 19</i> , 1956, that I last saw the deceased alive on <i>Aug.</i> , 1956, and that death occurred at <i>10 P. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>2926 E. Cold Spring Lane</i> DATE SIGNED <i>Dr. Henry Haase M.D. Balt. 14, Md.</i>							
ACTUAL SIGNATURE <i>Dr. Henry Haase</i>				M.D. <i>2926 E. Cold Spring Lane</i>			
PHYSICIAN'S NAME (Type) <i>Dr. Henry Haase M.D.</i>				Balt. 14, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/22/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #04</i>		24a. REC'D BY REGISTRAR <i>Oct. 22, 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filed with the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2, must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10074

CERTIFICATE OF DEATH

10055 31
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RANDALLSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RANDALLSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MCDONOGH RD</u>				d. STREET ADDRESS <u>MCDONOGH RD.</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>STEWART</u> Last <u>MCCABE</u>				4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 16, 1928</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIELD ENGINEER</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM STANFORD MCCABE</u>				14. MOTHER'S MAIDEN NAME <u>DOROTHY CHIDLOW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> (If yes, give year or dates of service) <u>1948-1953</u>				16. SOCIAL SECURITY NO. <u>212-269173</u>		17. INFORMANT Address <u>MCDONOGH RD RANDALLSTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 MONTHS.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>August 17, 1954</u> , to <u>Oct. 3, 1956</u> , that I last saw the deceased alive on <u>Oct. 2, 1956</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u>				ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD., BALTO. 7, MD.</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				DATE SIGNED <u>10/3/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>OCT 5 1956</u>				<u>Dr. Wm. Martin</u>			

BUREAU V. S.

OCT 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10075 CERTIFICATE OF DEATH

10056

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dulaney Valley Apts-900 Southerly Rd.		d. STREET ADDRESS Dulaney Valley Apts.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle N. Last McCOSH, Sr.		4. DATE OF DEATH Month Oct. Day 4 Year 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dr. Samuel A. McCosh		14. MOTHER'S MAIDEN NAME Louise Kellog	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-18-5646	
17. INFORMANT Mrs. James N. McCosh, Sr. - 900 Southerly Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ANAPLASTIC CARCINOMA Prostate DUE TO (c) Dec 1954		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 1951, to 4 Oct , 1956, that I last saw the deceased alive on 2 October , 1956, and that death occurred at 12:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Kennedy Waller		M.D. 514 Cathedral St. DATE SIGNED 5 Oct 1956	
PHYSICIAN'S NAME (Type) W. Kennedy Waller, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/6/56	
22c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons - Balto		ADDRESS 17 Md	
24a. REC'D BY REGISTRAR Oct 3, 1956		24b. REGISTRAR'S SIGNATURE R. W. Mabel Gray	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY	
5. STREET		6. HOUSE NO.	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. RACE	
11. OCCUPATION		12. CAUSE OF DEATH	
13. DATE OF BIRTH		14. PLACE OF BIRTH	
15. MARRIED		16. SINGLE	
17. COLOR		18. RELIGION	
19. EDUCATION		20. MARITAL STATUS	
21. DATE OF MARRIAGE		22. NAME OF SPOUSE	
23. DATE OF DEATH		24. PLACE OF DEATH	
25. NAME OF PHYSICIAN		26. NAME OF FUNERAL HOME	
27. NAME OF BURIAL PLACE		28. DATE OF BURIAL	
29. NAME OF CEMETERY		30. DATE OF INTERMENT	
31. NAME OF MINISTER		32. NAME OF CHURCH	
33. NAME OF CLERGYMAN		34. NAME OF CHURCH	
35. NAME OF CLERGYMAN		36. NAME OF CHURCH	
37. NAME OF CLERGYMAN		38. NAME OF CHURCH	
39. NAME OF CLERGYMAN		40. NAME OF CHURCH	
41. NAME OF CLERGYMAN		42. NAME OF CHURCH	
43. NAME OF CLERGYMAN		44. NAME OF CHURCH	
45. NAME OF CLERGYMAN		46. NAME OF CHURCH	
47. NAME OF CLERGYMAN		48. NAME OF CHURCH	
49. NAME OF CLERGYMAN		50. NAME OF CHURCH	
51. NAME OF CLERGYMAN		52. NAME OF CHURCH	
53. NAME OF CLERGYMAN		54. NAME OF CHURCH	
55. NAME OF CLERGYMAN		56. NAME OF CHURCH	
57. NAME OF CLERGYMAN		58. NAME OF CHURCH	
59. NAME OF CLERGYMAN		60. NAME OF CHURCH	
61. NAME OF CLERGYMAN		62. NAME OF CHURCH	
63. NAME OF CLERGYMAN		64. NAME OF CHURCH	
65. NAME OF CLERGYMAN		66. NAME OF CHURCH	
67. NAME OF CLERGYMAN		68. NAME OF CHURCH	
69. NAME OF CLERGYMAN		70. NAME OF CHURCH	
71. NAME OF CLERGYMAN		72. NAME OF CHURCH	
73. NAME OF CLERGYMAN		74. NAME OF CHURCH	
75. NAME OF CLERGYMAN		76. NAME OF CHURCH	
77. NAME OF CLERGYMAN		78. NAME OF CHURCH	
79. NAME OF CLERGYMAN		80. NAME OF CHURCH	
81. NAME OF CLERGYMAN		82. NAME OF CHURCH	
83. NAME OF CLERGYMAN		84. NAME OF CHURCH	
85. NAME OF CLERGYMAN		86. NAME OF CHURCH	
87. NAME OF CLERGYMAN		88. NAME OF CHURCH	
89. NAME OF CLERGYMAN		90. NAME OF CHURCH	
91. NAME OF CLERGYMAN		92. NAME OF CHURCH	
93. NAME OF CLERGYMAN		94. NAME OF CHURCH	
95. NAME OF CLERGYMAN		96. NAME OF CHURCH	
97. NAME OF CLERGYMAN		98. NAME OF CHURCH	
99. NAME OF CLERGYMAN		100. NAME OF CHURCH	

BUREAU V. S.

OCT 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10057

Reg. Dist. No.

10076

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marriotsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marriotsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. D. #1</u>				d. STREET ADDRESS <u>R. F. D. #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MAY</u> Last <u>MENTZELL</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 1, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>? Ewing</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Lemuel K. Mentzell-R.F.D.#1, Marriotsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of uterus</u> 174X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>not known</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1st</u> , 19 <u>56</u> , to <u>Oct. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 17</u> , 19 <u>56</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. E. Martin</u>				ADDRESS (Street, city or town, state) <u>Randallstown Md</u>			
PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN</u>				DATE SIGNED <u>md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balto. Md</u>				24a. REC'D BY REGISTRAR <u>DATE Oct. 22, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. PLACE OF BIRTH [Faint text]	
5. DATE OF DEATH [Faint text]		6. TIME OF DEATH [Faint text]		7. PLACE OF DEATH [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. DISEASE OR INJURY [Faint text]		10. MANNER OF DEATH [Faint text]		11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. NAME OF FUNERAL HOME [Faint text]		14. NAME OF CEMETERY [Faint text]		15. LOCATION OF BURIAL [Faint text]		16. DATE OF BURIAL [Faint text]	
17. NAME OF NEXT OF KIN [Faint text]		18. ADDRESS OF NEXT OF KIN [Faint text]		19. CITY OF NEXT OF KIN [Faint text]		20. STATE OF NEXT OF KIN [Faint text]	
21. NAME OF WITNESS [Faint text]		22. ADDRESS OF WITNESS [Faint text]		23. CITY OF WITNESS [Faint text]		24. STATE OF WITNESS [Faint text]	
25. NAME OF REGISTRAR [Faint text]		26. ADDRESS OF REGISTRAR [Faint text]		27. CITY OF REGISTRAR [Faint text]		28. STATE OF REGISTRAR [Faint text]	

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OCT 23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, and the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 12 Film 206 11-5-56 et
10077
CERTIFICATE OF DEATH

Reg. Dist. No. 10058 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>90 Armacost Nursing Home</i>		d. STREET ADDRESS <i>5111 Plainfield Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Mary U Milan</i>		4. DATE OF DEATH Month <i>October</i> Day <i>29th</i> Year <i>1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 21, 1881</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Matthew J. Milan, 5111 Plainfield Ave</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, left lower lobar (terminal)</i> DUE TO <i>450.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, generalized</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Gangrene, 3rd & 4th toes left foot</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1, 1956</i> to <i>Oct 29, 1956</i> that I last saw the deceased alive on <i>Oct 26, 1956</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5101 Belair Rd</i> DATE SIGNED <i>10/30/56</i>			
ACTUAL SIGNATURE <i>Charles V Sevcik</i> M.D.		PHYSICIAN'S NAME (Type) <i>Charles V Sevcik</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/31/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>NOV - 1 1956</i> 24b. REGISTRAR'S SIGNATURE <i>Mark Lloyd</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JANUARY 5, 1928	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		ATTORNEY AT LAW		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
APRIL 4, 1968		MEMPHIS, TENNESSEE		APRIL 8, 1968		MEMPHIS, TENNESSEE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968	

REMARKS: Deceased left home at 11:00 PM on April 4, 1968, and was not seen again. Cause of death: Heart disease. Manner of death: Natural.

REMARKS: Deceased was found on the floor of his home on April 4, 1968. Cause of death: Heart disease. Manner of death: Natural.

REMARKS: Deceased was found on the floor of his home on April 4, 1968. Cause of death: Heart disease. Manner of death: Natural.

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10078

CERTIFICATE OF DEATH

Reg. Dist. No.

33-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakland Rd.</u>		d. STREET ADDRESS <u>Oakland</u>	
3. NAME OF DECEASED (Type or print) <u>Estelle L. Miller</u>		4. DATE OF DEATH <u>October 23 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Own Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Charles Morris</u>		14. MOTHER'S MAIDEN NAME <u>Julia Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. John Keeney</u>		Address <u>Freeland, Md. Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		20g. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct. 18, 1956</u> , to <u>Oct. 23, 1956</u> , that I last saw the deceased alive on <u>Oct. 22, 1956</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>10/25/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u>		ADDRESS <u>Parkton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 26, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>10/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Freeland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10078

WARTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED <i>James Earl Ray</i></p>		<p>DATE OF BIRTH <i>May 19, 1928</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>May 14, 1968</i></p>		<p>PLACE OF DEATH <i>Prison, Nashville, Tennessee</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Writer</i></p>	
<p>RELIGION <i>Methodist</i></p>		<p>US CITIZENSHIP <i>Yes</i></p>	
<p>DATE OF BIRTH <i>May 19, 1928</i></p>		<p>PLACE OF BIRTH <i>Alton, Illinois</i></p>	
<p>DATE OF DEATH <i>May 14, 1968</i></p>		<p>PLACE OF DEATH <i>Prison, Nashville, Tennessee</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Writer</i></p>	
<p>RELIGION <i>Methodist</i></p>		<p>US CITIZENSHIP <i>Yes</i></p>	

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OCT 31 1956

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, who is to be filled in by the funeral director, must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9976 CERTIFICATE OF DEATH

Reg. Dist. No.

1006041

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>6906 SOLLERS POINT Rd.</u>		d. STREET ADDRESS <u>6906 SOLLERS PT. RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY SANDNER MINNICK</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH PATRICK SANDNER</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA MEYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FRANK MINNICK - 46 BROADSHIP</u>		Address <u>DUNDALK MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholecystitis and Hepatitis</u> DUE TO <u>585x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>70 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 10, 1956</u> to <u>Oct. 1, 1956</u> , that I last saw the deceased alive on <u>Sept. 30, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.		ADDRESS (Street, city or town, state) <u>6800 MORNINGTON RD BALTO. CO., MD.</u>	
DATE SIGNED <u>10/2/56</u>			
PHYSICIAN'S NAME (Type) <u>M.B. DAVIS MD</u>		<u>DUNDALK MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-4-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF J.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Lewis Bradley, Dundalk, MD</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10061

10079

CERTIFICATE OF DEATH

Reg. Dist. No. 45

ITEMS 18-21: G205 10-26-56L

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER				c. LENGTH OF STAY IN 1b 30 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 442 WHITETHORN WAY				d. STREET ADDRESS 442 WHITETHORN WAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALEXANDER STANLEY MOCARSKY				4. DATE OF DEATH Month Day Year OCTOBER 24, 1956 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 16, 1902	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDYMAN		10b. KIND OF BUSINESS OR INDUSTRY MARTIN'S	
11. BIRTHPLACE (State or foreign country) HARTFORD CONN.		12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME MOCARSKY		14. MOTHER'S MAIDEN NAME SAME.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> 16/18/19		16. SOCIAL SECURITY NO. 215 07 4914		17. INFORMANT MRS FLORENCE A. MOCARSKY		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20 , 19 56 , to Oct. 24 , 19 56 , that I last saw the deceased alive on Oct. 24 , 19 56 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Hi Octay M.D. 100 N. Calhoun St.							
PHYSICIAN'S NAME (Type) HI OKTAY							
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 10/29/56		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.				ADDRESS		24a. REC'D BY REGISTRAR DATE 10/26/56	
						24b. REGISTRAR'S SIGNATURE Caich Hurley	

BUREAU OF THE ARMY

[illegible]

701

1150

DECEMBER

1075 C. R. MILLER, JR.

BUREAU V. S.

OCT 29 1956

RECEIVED

10062

b. COUNTY
Baltimore

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

VS A1S (4)
ISM 9/SS

10081

10063
Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT W MORAN		4. DATE OF DEATH Month October Day 6 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/97
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.	11. IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Moran		14. MOTHER'S MAIDEN NAME Lillian M. Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes WWII		16. SOCIAL SECURITY NO. 705-09-1356	
17. INFORMANT Clin. Rec. Vets. Admin. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRESH THROMBOTIC OCCLUSION RIGHT ANTERIOR CORONARY ARTERY DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO UNKNOWN (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD HEALED APICAL MYOCARDIAL INFARCTION			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. Month 19 Day 19 Year 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 2, 1956 , to October 6, 1956 , that I saw the deceased alive on October 6, 1956 , and that death occurred at 9:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED October 6, 1956 ACTUAL SIGNATURE Arthur G. Edwards M.D. Fort Howard, Md. PHYSICIAN'S NAME (Type) ARTHUR G. EDWARDS, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-6-56	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons, Inc.		24. REC'D BY REGISTRAR 1956	
ADDRESS 1905 York Rd., Balto.		24b. REGISTRAR'S SIGNATURE Lawson L. Farber	

VS AND 15M 9/35

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. _____ Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, _____ Page 1 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15
15M 9/35

BUREAU V.

9561 6 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10082 CERTIFICATE OF DEATH

10064 *37*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>42 Croftley Rd. Baltimore County</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>42 Croftley Road, Lutherville, Md.</i>			d. STREET ADDRESS <i>318 E. 39th St</i>			
3. NAME OF DECEASED (Type or print) <i>Ada May Johnson Mosberg</i>			4. DATE OF DEATH Month <i>October</i> Day <i>25</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>Nov. 24 1889</i>		9. AGE (In years lost birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>William Solomon Johnson</i>			
14. MOTHER'S MAIDEN NAME <i>Amelia Adline Johnson</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Dr Wm. Mosberg</i> Address <i>Baltimore 120 Hawthorne Rd. - 10</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ca</i> <i>170x</i> DUE TO <i>Carcinoma of Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>-</i> DUE TO (c) <i>-</i>					INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <i>Sept 9, 1956</i> to <i>Oct 24, 1956</i> , that I last saw the deceased alive on <i>Oct 24, 1956</i> , and that death occurred at <i>10:15 P.M.</i> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Lester A. Wall Jr.</i>			ADDRESS (Street, city or town, state) <i>1039 St Paul St, Baltimore 2 Md</i>			
PHYSICIAN'S NAME (Type) <i>LESTER A. WALL JR.</i>			DATE SIGNED <i>10/25/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-29-1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		
22d. LOCATION (City, town, or county) <i>Woodlawn, Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>G Howard Strong</i> ADDRESS <i>3207 W. North Ave</i>				
24a. REC'D BY REGISTRAR <i>29 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Arnee MacRae</i>				

CERTIFICATE OF DEATH

1956

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASS. REG. NO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF CLERK</p>	
<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF TOWNSHIP CLERK</p>		<p>20. SIGNATURE OF VOTING CLERK</p>	
<p>21. SIGNATURE OF VOTING CLERK</p>		<p>22. SIGNATURE OF VOTING CLERK</p>		<p>23. SIGNATURE OF VOTING CLERK</p>		<p>24. SIGNATURE OF VOTING CLERK</p>	
<p>25. SIGNATURE OF VOTING CLERK</p>		<p>26. SIGNATURE OF VOTING CLERK</p>		<p>27. SIGNATURE OF VOTING CLERK</p>		<p>28. SIGNATURE OF VOTING CLERK</p>	
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<p>33. SIGNATURE OF VOTING CLERK</p>		<p>34. SIGNATURE OF VOTING CLERK</p>		<p>35. SIGNATURE OF VOTING CLERK</p>		<p>36. SIGNATURE OF VOTING CLERK</p>	
<p>37. SIGNATURE OF VOTING CLERK</p>		<p>38. SIGNATURE OF VOTING CLERK</p>		<p>39. SIGNATURE OF VOTING CLERK</p>		<p>40. SIGNATURE OF VOTING CLERK</p>	
<p>41. SIGNATURE OF VOTING CLERK</p>		<p>42. SIGNATURE OF VOTING CLERK</p>		<p>43. SIGNATURE OF VOTING CLERK</p>		<p>44. SIGNATURE OF VOTING CLERK</p>	
<p>45. SIGNATURE OF VOTING CLERK</p>		<p>46. SIGNATURE OF VOTING CLERK</p>		<p>47. SIGNATURE OF VOTING CLERK</p>		<p>48. SIGNATURE OF VOTING CLERK</p>	
<p>49. SIGNATURE OF VOTING CLERK</p>		<p>50. SIGNATURE OF VOTING CLERK</p>		<p>51. SIGNATURE OF VOTING CLERK</p>		<p>52. SIGNATURE OF VOTING CLERK</p>	
<p>53. SIGNATURE OF VOTING CLERK</p>		<p>54. SIGNATURE OF VOTING CLERK</p>		<p>55. SIGNATURE OF VOTING CLERK</p>		<p>56. SIGNATURE OF VOTING CLERK</p>	
<p>57. SIGNATURE OF VOTING CLERK</p>		<p>58. SIGNATURE OF VOTING CLERK</p>		<p>59. SIGNATURE OF VOTING CLERK</p>		<p>60. SIGNATURE OF VOTING CLERK</p>	
<p>61. SIGNATURE OF VOTING CLERK</p>		<p>62. SIGNATURE OF VOTING CLERK</p>		<p>63. SIGNATURE OF VOTING CLERK</p>		<p>64. SIGNATURE OF VOTING CLERK</p>	
<p>65. SIGNATURE OF VOTING CLERK</p>		<p>66. SIGNATURE OF VOTING CLERK</p>		<p>67. SIGNATURE OF VOTING CLERK</p>		<p>68. SIGNATURE OF VOTING CLERK</p>	
<p>69. SIGNATURE OF VOTING CLERK</p>		<p>70. SIGNATURE OF VOTING CLERK</p>		<p>71. SIGNATURE OF VOTING CLERK</p>		<p>72. SIGNATURE OF VOTING CLERK</p>	
<p>73. SIGNATURE OF VOTING CLERK</p>		<p>74. SIGNATURE OF VOTING CLERK</p>		<p>75. SIGNATURE OF VOTING CLERK</p>		<p>76. SIGNATURE OF VOTING CLERK</p>	
<p>77. SIGNATURE OF VOTING CLERK</p>		<p>78. SIGNATURE OF VOTING CLERK</p>		<p>79. SIGNATURE OF VOTING CLERK</p>		<p>80. SIGNATURE OF VOTING CLERK</p>	
<p>81. SIGNATURE OF VOTING CLERK</p>		<p>82. SIGNATURE OF VOTING CLERK</p>		<p>83. SIGNATURE OF VOTING CLERK</p>		<p>84. SIGNATURE OF VOTING CLERK</p>	
<p>85. SIGNATURE OF VOTING CLERK</p>		<p>86. SIGNATURE OF VOTING CLERK</p>		<p>87. SIGNATURE OF VOTING CLERK</p>		<p>88. SIGNATURE OF VOTING CLERK</p>	
<p>89. SIGNATURE OF VOTING CLERK</p>		<p>90. SIGNATURE OF VOTING CLERK</p>		<p>91. SIGNATURE OF VOTING CLERK</p>		<p>92. SIGNATURE OF VOTING CLERK</p>	
<p>93. SIGNATURE OF VOTING CLERK</p>		<p>94. SIGNATURE OF VOTING CLERK</p>		<p>95. SIGNATURE OF VOTING CLERK</p>		<p>96. SIGNATURE OF VOTING CLERK</p>	
<p>97. SIGNATURE OF VOTING CLERK</p>		<p>98. SIGNATURE OF VOTING CLERK</p>		<p>99. SIGNATURE OF VOTING CLERK</p>		<p>100. SIGNATURE OF VOTING CLERK</p>	

BUREAU V. S.

OCT 29 1956

RECEIVED

10083

CERTIFICATE OF DEATH

10065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 55 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 104 North Greene Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle P. Last MULLEN				4. DATE OF DEATH Month October Day 13 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1895		9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer			10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Theodore Mullen				14. MOTHER'S MAIDEN NAME Mary Bage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 577-14-9760		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 543X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Gastritis with hemorrhage 2. Renal Cortical Hemorrhages						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 19, 1956 to October 13, 1956 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 10/15/56							
ACTUAL SIGNATURE C. J. Papastrat MD				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Blight, Inc.				ADDRESS 6009 Harford Rd., Balto. Md.		24a. REC'D BY REGISTRAR 10/16/56	
				24b. REGISTRAR'S SIGNATURE Harmon L. Harbo			

CERTIFICATE OF DEATH

1956

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Usual residence		8. Cause of death		9. Manner of death	
10. Physician		11. Hospital		12. Burial place	
13. Signature of physician		14. Signature of registrar		15. Signature of medical examiner	
16. Date of registration		17. Registrar's name		18. Registrar's title	
19. Registrar's address		20. Registrar's telephone		21. Registrar's office	
22. Registrar's signature		23. Registrar's stamp		24. Registrar's seal	
25. Registrar's date		26. Registrar's time		27. Registrar's place	
28. Registrar's office		29. Registrar's telephone		30. Registrar's address	
31. Registrar's signature		32. Registrar's stamp		33. Registrar's seal	
34. Registrar's date		35. Registrar's time		36. Registrar's place	
37. Registrar's office		38. Registrar's telephone		39. Registrar's address	
40. Registrar's signature		41. Registrar's stamp		42. Registrar's seal	
43. Registrar's date		44. Registrar's time		45. Registrar's place	
46. Registrar's office		47. Registrar's telephone		48. Registrar's address	
49. Registrar's signature		50. Registrar's stamp		51. Registrar's seal	
52. Registrar's date		53. Registrar's time		54. Registrar's place	
55. Registrar's office		56. Registrar's telephone		57. Registrar's address	
58. Registrar's signature		59. Registrar's stamp		60. Registrar's seal	
61. Registrar's date		62. Registrar's time		63. Registrar's place	
64. Registrar's office		65. Registrar's telephone		66. Registrar's address	
67. Registrar's signature		68. Registrar's stamp		69. Registrar's seal	
70. Registrar's date		71. Registrar's time		72. Registrar's place	
73. Registrar's office		74. Registrar's telephone		75. Registrar's address	
76. Registrar's signature		77. Registrar's stamp		78. Registrar's seal	
79. Registrar's date		80. Registrar's time		81. Registrar's place	
82. Registrar's office		83. Registrar's telephone		84. Registrar's address	
85. Registrar's signature		86. Registrar's stamp		87. Registrar's seal	
88. Registrar's date		89. Registrar's time		90. Registrar's place	
91. Registrar's office		92. Registrar's telephone		93. Registrar's address	
94. Registrar's signature		95. Registrar's stamp		96. Registrar's seal	
97. Registrar's date		98. Registrar's time		99. Registrar's place	
100. Registrar's office		101. Registrar's telephone		102. Registrar's address	

BUREAU V. 81

OCT 16 1956

RECEIVED

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10066

10084 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5632 Johnnycake Rd.</u>				STREET ADDRESS (If rural give location) <u>5632 Johnnycake Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Frank</u> (Middle) <u>Nardo</u> (Last)				(Month) <u>Oct.</u> (Day) <u>11</u> (Year) <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 10, 1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self. Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fruit Produce</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Nardo</u>				14. MOTHER'S MAIDEN NAME <u>Frances Marino</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>Mrs. James Biondo 5632 Johnnycake Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) <u>CARCINOMA RECTUM WITH</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>METASTASES TO LUNGS</u>						<u>2 Mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1/23/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>INOPERABLE CARCINOMA RECTUM</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>JAN 1, 1956</u> , to <u>OCT 11, 1956</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>56</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert A. Neely</u>				ADDRESS (Street, city, town, state) <u>301 MD. Arts Bldg Balto-1</u>		DATE SIGNED <u>10/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>OCT 15 1956</u>		REGISTRAR'S SIGNATURE <u>R. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Earley Funeral Home Catonsville, Md.</u>		ADDRESS	

BOOK CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-CERTIFICATE NO. 12

1956 OCT 15

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
MARRIAGE		OCCUPATION		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL ATTENDANCE		POST-MORTEM EXAMINATION	
SIGNATURE OF REGISTRAR		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF POST-MORTEM EXAMINER	
DATE OF REGISTRATION		PLACE OF REGISTRATION		OFFICE OF REGISTRATION	

BUREAU V. 1

OCT 15 1956

RECEIVED

10085

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>28</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of Pines</u>				d. STREET ADDRESS <u>2632 Frederick Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie L Ogle</u>				4. DATE OF DEATH Month Day Year <u>10 11 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/91</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Philip Moore</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Grace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>M. Leo Ogle</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Liver (Primary)</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Insipidus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec-31, 1954</u> to <u>10/11, 1956</u> , that I last saw the deceased alive on <u>10/11, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>Catonville, Md</u>			
PHYSICIAN'S NAME (Type) <u>S. LLOYD JOHNSON, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/15/56</u>		<u>Good Shepard</u>		<u>Howard Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>MacDonald Son Caton, 28</u>				24a. REC'D BY REGISTRAR DATE <u>10/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>T.E. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

See Note on

PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION	
Maryland		1910		Male		White		High School		Farmer		Married		Roman Catholic	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		PLACE OF INTERMENT	
Maryland		1956		10:00 AM		Heart Disease		Natural		Maryland		Maryland		Maryland	
PLACE OF INTERMENT		DATE OF INTERMENT		TIME OF INTERMENT		CAUSE OF INTERMENT		MANNER OF INTERMENT		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		PLACE OF INTERMENT	
Maryland		1956		10:00 AM		Heart Disease		Natural		Maryland		Maryland		Maryland	
PLACE OF INTERMENT		DATE OF INTERMENT		TIME OF INTERMENT		CAUSE OF INTERMENT		MANNER OF INTERMENT		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		PLACE OF INTERMENT	
Maryland		1956		10:00 AM		Heart Disease		Natural		Maryland		Maryland		Maryland	

BUREAU V. S.

OCT 17 1956

RECEIVED

1
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10086

CERTIFICATE OF DEATH

10068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Baltimore, Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 18yrlmth2ldys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2028 W. Lanvale Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Ohlendorf Last				4. DATE OF DEATH Month October Day 29 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1870		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) MD.	(State)
21. I certify that I attended the deceased from July 1, 1953 , to October 29, 1956 , that I last saw the deceased alive on Oct. 29, 1956 , and that death occurred at 2:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 10-29-56							
ACTUAL SIGNATURE Stella Wachslar		M.D. Stella Wachslar, M. D. Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-2-56	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		22d. LOCATION (City, town, or county) Baltimore		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Tuman Schuch				ADDRESS 3512 FREDERICK ST.		24a. REC'D BY REGISTRAR DATE 1956	24b. REGISTRAR'S SIGNATURE V. E. Hany

CERTIFICATE OF DEATH

Reg. Dist. No.

9977

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Same b. COUNTY as #1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22		c. LENGTH OF STAY IN 1b 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7990 ST. MONICA DRIVE		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) MARGARET ELIZABETH ORNDUFF		4. DATE OF DEATH Month OCT. Day 4 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AGE 71 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY WYNDALE, VIRGINIA	
13. FATHER'S NAME TOBY STARK		14. MOTHER'S MAIDEN NAME JNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. CHARLES SAWYER - SAME		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Disease DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured (ununioned) hips for 5 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 28, 1956 to 10/3, 1956 that I last saw the deceased alive on 10/3, 1956 , and that death occurred at 9 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spasnowtown, 10/7/56		DATE SIGNED 10/7/56	
ACTUAL SIGNATURE David Owens		M.D. Spasnowtown, 10/7/56	
PHYSICIAN'S NAME (Type) David Owens			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-7-56	
22c. NAME OF CEMETERY OR CREMATORY KREGER KNOLL		22d. LOCATION (City, town, or county) (State) ABINGDON, VIRGINIA	
24a. REC'D BY REGISTRAR DATE 8 1956		24b. REGISTRAR'S SIGNATURE 24m Kelly	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar provided burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 10

274116
1 # 10

BUREAU V. 2

OCT 8 1955

RECEIVED

10-5-56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10070

10087

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cub Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cub Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10037 HARFORD Rd.</u>		d. STREET ADDRESS <u>10037 HARFORD Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>M</u> Last <u>PEARCE</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28 1904</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Pearce</u>		14. MOTHER'S MAIDEN NAME <u>MARY HARMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Edith Pearce</u>	
17. INFORMANT <u>Edith Pearce</u>		Address <u>10037 HARFORD Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intoxication, alcoholic, acute</u> DUE TO (b) <u>Alcoholism Chronic</u> DUE TO (c) <u>Cardiovascular, hypertension, mild</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>for about 19 years</u> , to <u>1956</u> , that I last saw the deceased alive on <u>Oct. 21</u> , 19 <u>56</u> , and that death occurred at <u>11:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5901 Ayleshire Road</u> DATE SIGNED <u>PA</u>			
ACTUAL SIGNATURE <u>Louis N. Rudin</u>		M.D. <u>Baltimore 12, Md</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. RUDIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-25-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Center Presbyterian Church</u>		22d. LOCATION (City, town, or county) (State) <u>New Park PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans & Son</u>		ADDRESS <u>3802 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>Dr. M. L. Lacey</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. M. L. Lacey</u>	

10088

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 11 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 616 E. St		d. STREET ADDRESS 616 E. St.	
3. NAME OF DECEASED (Type or print) First Dora Middle M. Last Peters		4. DATE OF DEATH Month October Day 19 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph Smith	
14. MOTHER'S MAIDEN NAME Mary Little		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Lillian Woodhead Address 602 E. St. Sparrows Pt.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic CVD DUE TO (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 30 min. 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis (severe)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1955 , to Oct. 19, 1956 , that I last saw the deceased alive on Oct. 19, 1956 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David Owens		ADDRESS (Street, city or town, state) 914 D St. Baltimore, Md.	
DATE SIGNED 10/19/56		DATE SIGNED	
PHYSICIAN'S NAME (Type) David Owens, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 22, 1956	22c. NAME OF CEMETERY OR CREMATORY Oaklawn	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE 22 1956		24b. REGISTRAR'S SIGNATURE Samson L. Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director must fill in the space on page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and return them to the registrar promptly for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove the paper pages 1 and 2 and fill in with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10089 CERTIFICATE OF DEATH

10072 37
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 25 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25		3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 02 Mt. Wilson State Hospital		d. STREET ADDRESS 4113 Hyden Court	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Pierce		4. DATE OF DEATH Month 10 Day 27 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/92
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Appen		14. MOTHER'S MAIDEN NAME Mary Lawless	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records,		Address Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X (b) Hypertension DUE TO (c) Twelve		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Advanced Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/2 , 19 56 , to 10/27 , 19 56 , that I last saw the deceased alive on 10/27 , 19 56 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/27/56			
ACTUAL SIGNATURE William Newcomer M.D.			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Mt. Wilson, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/56	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE McGully Funeral Home		ADDRESS 130 E. Fort Avenue	
24a. REC'D BY REGISTRAR Oct 30 1956		24b. REGISTRAR'S SIGNATURE Kathleen Newell	

CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM WILSON		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Boston, Mass.		5. OCCUPATION Engineer		6. MARITAL STATUS Married	
7. DATE OF DEATH Jan 30 1956		8. TIME OF DEATH 10:30 AM		9. CAUSE OF DEATH Heart Disease	
10. PLACE OF DEATH Home		11. SIGNATURE OF PHYSICIAN J. W. Smith		12. SIGNATURE OF REGISTRAR A. B. Jones	
13. SIGNATURE OF DECEASED (If living)		14. SIGNATURE OF WITNESSES J. W. Smith, A. B. Jones		15. SIGNATURE OF DECEASED (If living)	
16. SIGNATURE OF DECEASED (If living)		17. SIGNATURE OF DECEASED (If living)		18. SIGNATURE OF DECEASED (If living)	
19. SIGNATURE OF DECEASED (If living)		20. SIGNATURE OF DECEASED (If living)		21. SIGNATURE OF DECEASED (If living)	
22. SIGNATURE OF DECEASED (If living)		23. SIGNATURE OF DECEASED (If living)		24. SIGNATURE OF DECEASED (If living)	
25. SIGNATURE OF DECEASED (If living)		26. SIGNATURE OF DECEASED (If living)		27. SIGNATURE OF DECEASED (If living)	
28. SIGNATURE OF DECEASED (If living)		29. SIGNATURE OF DECEASED (If living)		30. SIGNATURE OF DECEASED (If living)	
31. SIGNATURE OF DECEASED (If living)		32. SIGNATURE OF DECEASED (If living)		33. SIGNATURE OF DECEASED (If living)	
34. SIGNATURE OF DECEASED (If living)		35. SIGNATURE OF DECEASED (If living)		36. SIGNATURE OF DECEASED (If living)	
37. SIGNATURE OF DECEASED (If living)		38. SIGNATURE OF DECEASED (If living)		39. SIGNATURE OF DECEASED (If living)	
40. SIGNATURE OF DECEASED (If living)		41. SIGNATURE OF DECEASED (If living)		42. SIGNATURE OF DECEASED (If living)	
43. SIGNATURE OF DECEASED (If living)		44. SIGNATURE OF DECEASED (If living)		45. SIGNATURE OF DECEASED (If living)	
46. SIGNATURE OF DECEASED (If living)		47. SIGNATURE OF DECEASED (If living)		48. SIGNATURE OF DECEASED (If living)	
49. SIGNATURE OF DECEASED (If living)		50. SIGNATURE OF DECEASED (If living)		51. SIGNATURE OF DECEASED (If living)	
52. SIGNATURE OF DECEASED (If living)		53. SIGNATURE OF DECEASED (If living)		54. SIGNATURE OF DECEASED (If living)	
55. SIGNATURE OF DECEASED (If living)		56. SIGNATURE OF DECEASED (If living)		57. SIGNATURE OF DECEASED (If living)	
58. SIGNATURE OF DECEASED (If living)		59. SIGNATURE OF DECEASED (If living)		60. SIGNATURE OF DECEASED (If living)	
61. SIGNATURE OF DECEASED (If living)		62. SIGNATURE OF DECEASED (If living)		63. SIGNATURE OF DECEASED (If living)	
64. SIGNATURE OF DECEASED (If living)		65. SIGNATURE OF DECEASED (If living)		66. SIGNATURE OF DECEASED (If living)	
67. SIGNATURE OF DECEASED (If living)		68. SIGNATURE OF DECEASED (If living)		69. SIGNATURE OF DECEASED (If living)	
70. SIGNATURE OF DECEASED (If living)		71. SIGNATURE OF DECEASED (If living)		72. SIGNATURE OF DECEASED (If living)	
73. SIGNATURE OF DECEASED (If living)		74. SIGNATURE OF DECEASED (If living)		75. SIGNATURE OF DECEASED (If living)	
76. SIGNATURE OF DECEASED (If living)		77. SIGNATURE OF DECEASED (If living)		78. SIGNATURE OF DECEASED (If living)	
79. SIGNATURE OF DECEASED (If living)		80. SIGNATURE OF DECEASED (If living)		81. SIGNATURE OF DECEASED (If living)	
82. SIGNATURE OF DECEASED (If living)		83. SIGNATURE OF DECEASED (If living)		84. SIGNATURE OF DECEASED (If living)	
85. SIGNATURE OF DECEASED (If living)		86. SIGNATURE OF DECEASED (If living)		87. SIGNATURE OF DECEASED (If living)	
88. SIGNATURE OF DECEASED (If living)		89. SIGNATURE OF DECEASED (If living)		90. SIGNATURE OF DECEASED (If living)	
91. SIGNATURE OF DECEASED (If living)		92. SIGNATURE OF DECEASED (If living)		93. SIGNATURE OF DECEASED (If living)	
94. SIGNATURE OF DECEASED (If living)		95. SIGNATURE OF DECEASED (If living)		96. SIGNATURE OF DECEASED (If living)	
97. SIGNATURE OF DECEASED (If living)		98. SIGNATURE OF DECEASED (If living)		99. SIGNATURE OF DECEASED (If living)	
100. SIGNATURE OF DECEASED (If living)		101. SIGNATURE OF DECEASED (If living)		102. SIGNATURE OF DECEASED (If living)	

RECEIVED
JCT 30 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.

10090 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10073 44

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
c. LENGTH OF STAY IN 1b 21 Days		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1 Park Lane	
3. NAME OF DECEASED (Type or print) First LEON Middle (NMI) Last PINDER		4. DATE OF DEATH Month October Day 27 Year 19 56	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/6/10
9. AGE (In years lost birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cannery	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Caleb Pinder		14. MOTHER'S MAIDEN NAME Ella Pinder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. 214 07 8956	
17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS WITH METASTASIS, GENERALIZED DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1956 , to October 27, 1956 , and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 10/30/56 ACTUAL SIGNATURE Constantine J. Papastrat M.D. PHYSICIAN'S NAME (Type) CONSTANTINE J. PAPASTRAT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-56	
22c. NAME OF CEMETERY OR CREMATORY Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		24b. REGISTRAR'S SIGNATURE Lawson L. Eberly	
ADDRESS 802-04 Madison Ave. Baltimore, Md.		DATE NOV 2 1956	

BUREAU V. 5

NOV 2 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10091
CERTIFICATE OF DEATH

10074 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle G. Last POOLE				4. DATE OF DEATH Month October Day 8 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1898	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 58		IF UNDER 24 HRS. Days 58 Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Cement Work		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jerry Poole				14. MOTHER'S MAIDEN NAME Lucinda Wood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 150x DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Pulmonary emphysema 2. Arteriosclerosis, generalized				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 4 , 19 56 , to October 8 , 19 56 , and that death occurred at 3:50A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND			
ACTUAL SIGNATURE Irving Freeman				DATE SIGNED 10/8/56			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802-04 Madison Ave.			
24a. REC'D BY REGISTRAR Ed. 25, 1956				24b. REGISTRAR'S SIGNATURE Lawson L. Garber			

Charles R. Law Mortuary Baltimore, Maryland

may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, who should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10092

CERTIFICATE OF DEATH

10075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> 2605 HICKRY AVE. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>2605 HICKRY AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA M. PRZYWARA</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24 1885</u>
9. AGE (in years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. GALKA</u>		14. MOTHER'S MAIDEN NAME <u>UNK.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Przywara Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 422.1 DUE TO (b) <u>Arterio-Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 da</u> <u>5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1/50</u> , 19 <u>51</u> , to <u>10/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/25/56</u> , 19 <u>56</u> and that death occurred at <u>7:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph G. Laukaitis</u>		DATE SIGNED <u>10/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Joseph G. Laukaitis, M.D.</u>		ADDRESS (Street, city or town, state) <u>679 Washington Blvd Balto 30nd Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>FRED. W. OZAZEWSKI</u>		24a. REC'D BY REGISTRAR <u>Oct 27 1956</u>	
ADDRESS <u>1930 EASTERN AVE.</u>		24b. REGISTRAR'S SIGNATURE <u>R. W. DeLoach</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10076
Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>500 HICKORY LANE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> b. STATE <u>MARYLAND</u> . c. COUNTY <u>BALTIMORE</u> . <u>BETHEL</u> CONN.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON MD.</u>		c. LENGTH OF STAY IN 1b <u>45X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>500 HICKORY LANE</u>		d. STREET ADDRESS <u>SUNSET HILL ROAD</u> <u>500 HICKORY LANE</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN F. QUICK.</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1902</u>
9. AGE (In years last birthday) <u>54 5/16</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE PRESIDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MERCANTILE FOOD DIST. New York</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nelson Quick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Holmes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family Information</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia - Aspiration of</u> <u>921.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>BOLUS OF MEAT</u> DUE TO <u>322.0</u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Alcoholism</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Aspirated large hunk of meat</u>		20c. TIME OF INJURY Month, Day, Year <u>9:36 a.m. 10/11 1956</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	
20f. (City or town) <u>500 Hickory Lane - Balto MD</u>		(County) <u>BALTIMORE</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. S. Fisher MD</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/12/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 15, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, lawn, or county) <u>Bethel, Conn.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons, Towson, Maryland</u> <u>John C. Freeland, Danbury, Conn.</u>		24a. REC'D BY REGISTRAR <u>DATE 10/12/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files or your file for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. RACE [REDACTED]	
5. DATE OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. SIGNATURE OF EXAMINER [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF CORONER [REDACTED]	

RECEIVED
OCT 15 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 or 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

10094
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Roanoke</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>68 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STEVE</u> Middle <u>D.</u> Last <u>RAGLAND</u>		4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1915</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Langley Field</u>	
11. BIRTHPLACE (State or foreign country) <u>Oxford, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sam Ragland</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Wooten</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>567-34-2605</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard</u>		Address <u>Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>410 X</u> DUE TO <u>MITRAL VALVULOTOMY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Heart Disease, Mitral and Aortic Valves - Duration unknown</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27</u> , 19 <u>56</u> , to <u>October 3</u> , 19 <u>56</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irving Freeman</u> M.D.		ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u>	
DATE SIGNED <u>10/4/56</u>			
PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10-4-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Roanoke County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Rd., Balto. Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 8 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>			

SHIPPED TO: John N. Oakey and Son, Church Ave., Roanoke, Va.

OCT 8 1956

RECEIVED

10095

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

Wm. Valentine Matthew Ratajczak

2. DATE
OF
DEATH

Oct, 16, th, 1956

3. PLACE OF DEATH

A. Baltimore City, Maryland 7213 Conley Street

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

At Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE before admision)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 24

D. STREET ADDRESS (If rural, give location)

7213 Conley Street

c. Length of stay in Baltimore 76 yrs

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb, 12-1879

9. AGE (In years
last birthday)

77

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Ratajczak

14. MOTHER'S MAIDEN NAME

Antoinette Sobczak

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
212-01-9401

17. INFORMANT

ADDRESS

Veronica Stachowiak 7213 Conley Street

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

1 week?

ML CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH. ENTER NO.
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☒ NO ☐21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 19 54 to Oct 16 19 56, that (I) (we) last saw the deceased alive on Oct 16 19 56, and that death occurred at 12 Noon, from the causes and on the date stated above.

23A. SIGNATURE

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☐

23B. ADDRESS

2936 E. Balto St

23C. DATE SIGNED

10/16/56

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct, 20-1956

24C. NAME OF CEMETERY

St. Stanislaus Cemetery

24D. LOCATION (City, town, or county)

1300 Dundalk Ave-Balto, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 17 1956

H. J. [Signature]

George R. Weber 745 S. Ann St

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

MAXYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED

1956 OCT 19

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10096

CERTIFICATE OF DEATH

10079 44
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balt	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 323, Old North Point Rd.		d. STREET ADDRESS Box 323, Old North Point Rd.	
3. NAME OF DECEASED (Type or print) First Sebastian Middle Rauh Last Rauh		4. DATE OF DEATH Month October Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Steel Worker	9. AGE (In years last birthday) 75 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Rauh		14. MOTHER'S MAIDEN NAME Augustina Boehner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-9185	
17. INFORMANT George Rauh		Address 1915 Ellenwood Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA of Rectum C 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Genital Metastasis (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 11 Mo's.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 30 , 19 56 , to Oct 1 , 19 56 , that I last saw the deceased alive on Oct 1 , 19 56 , and that death occurred at 2:17 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE M. B. Davis		ADDRESS (Street, city or town, state) DATE SIGNED 6800 MORRINGTON CON 10/1/56	
PHYSICIAN'S NAME (Type) M. B. DAVIS		Dundak-vi Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 4, 1956	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street		24a. REC'D BY REGISTRAR DATE 1056	
		24b. REGISTRAR'S SIGNATURE Rawson L. Farber	

BUREAU V. S.

OCT 3 1956

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10097

CERTIFICATE OF DEATH

10080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Reisterstown Rd.				d. STREET ADDRESS 303 Reisterstown Rd.			
3. NAME OF DECEASED (Type or print) First CHARLES Middle HARRY REISINGER Last				4. DATE OF DEATH Month Oct. Day 2 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1885	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Office Engineer				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Frederick P. Reisinger				14. MOTHER'S MAIDEN NAME Julia Dietrich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-5575		17. INFORMANT Mrs. G. Hartman Blamberg - 216 Chancery Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Art. Sclerosis							INTERVAL BETWEEN ONSET AND DEATH 34 hours 29 1/2 5 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. , 1954, to Oct 2 , 1956, that I last saw the deceased alive on Oct 2 , 1956, and that death occurred at 230 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1331 Reisterstown Rd Pikesville, Md DATE SIGNED 10/3/56 ACTUAL SIGNATURE James H. Miller M.D. PHYSICIAN'S NAME (Type) Dr. James H. Miller							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. 17, Md				24a. REC'D BY REGISTRAR DATE Oct 3, 1956		24b. REGISTRAR'S SIGNATURE Dorothy Henckels	

MAZDAY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10098

CERTIFICATE OF DEATH

10081

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) Phillip P. Rice.			2. DATE OF DEATH October 2, 1956		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 3V01.4		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Shady Nook Nursing Home.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 4003 Hickory Ave		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower.	8. DATE OF BIRTH October 8/1909		9. AGE (in years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) Traffic		10B. KIND OF BUSINESS OR INDUSTRY McCormick & Co.	11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Rice.			14. MOTHER'S MAIDEN NAME Lilly M. Wilder.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 213 10 8187		16. SOCIAL SECURITY NO. 213 10 8187	17. INFORMANT ADDRESS Mrs. Vivian Caga. 4003 Hickory Ave.		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 177X ANTECEDENT CAUSES		CAUSE OF DEATH Brocho Pneumonia	INTERVAL BETWEEN ONSET AND DEATH 3 Days.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO Carcinomatosis	4 years.
		(B) DUE TO Primary tumor Prostate	4 years
		(C)	

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (month) (day) (year) (hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from August 1956 to October 2, 1956 , that (I) (we) last saw the deceased alive on Oct 1, 1956 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.				
23A. SIGNATURE W. L. Chamberlain		23B. ADDRESS 1118 St. Paul St.		23C. DATE SIGNED 10/3/56
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct 5, 1956	24C. NAME OF CEMETERY OR CREMATORY Lorraine Park.		24D. LOCATION (City, town, or county) (State) Windsor Mill Rd. Md.
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR Justin E. Donovan - 3818 Roland		

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER.

10099

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>50 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>(NMI)</u> Last <u>ROWAN</u>				4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/88</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storeroom Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Rowan</u>				14. MOTHER'S MAIDEN NAME <u>Mary McNamara</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>361-03-9236</u>		17. INFORMANT Address <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA PANCREAS WITH MEDIASTINAL, HEPATIC</u> <u>157X</u> DUE TO <u>BONE METASTASIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SUPERIOR VENA CAVA OBSTRUCTION</u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 17</u> , 19 <u>56</u> , to <u>October 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>October 6</u> , 19 <u>56</u> , and that death occurred at <u>4:00 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. Veterans Administration Hospital</u> <u>10/6/56</u>							
ACTUAL SIGNATURE <u>Walter J. Pijanowski</u>		PHYSICIAN'S NAME (Type) <u>WALTER J. PIJANOWSKI, M. D.</u> <u>FORT HOWARD, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u> ADDRESS <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto., Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10 10 56</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Garber</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 of this certificate should be filled in by the funeral director, and the remainder by the attending physician. The law requires that the death certificate be executed within 24 hours after death. Part 1 of this certificate should be filled in by the funeral director, and the remainder by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. 2

OCT 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completed, it should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10100

CERTIFICATE OF DEATH

10083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>16 Fusting Ave.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nursing Home</u>		d. STREET ADDRESS <u>6107 Regent Park Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Vincent</u> Last <u>Russell</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William Russell</u>		14. MOTHER'S MAIDEN NAME <u>Roseanna Patterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>William T. Russell</u>		Address <u>6107 Regent Park Road, Balto. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular renal disease</u> <u>442X</u> DUE TO (b) <u>Acute Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. n. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan. 11, 1952</u> to <u>October 25, 1956</u> , that I last saw the deceased alive on <u>October 25, 1956</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4116 Edmondson Avenue</u> DATE SIGNED <u>10/26/56</u>			
ACTUAL SIGNATURE <u>George A. Knipp</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>George A. Knipp, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co., Inc.</u>		ADDRESS <u>4905 York Road Balto. 12, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>P. E. Harrys</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10101

CERTIFICATE OF DEATH

1008448
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Leslie Ave.		d. STREET ADDRESS 209 Leslie Ave.	
3. NAME OF DECEASED (Type or print) First HERMAN Middle Rudolph Last Schmidt		4. DATE OF DEATH Month Oct Day 29 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 May 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cobbler		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herman R. Schmidt	
14. MOTHER'S MAIDEN NAME Unknown Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 218-14-9866		17. INFORMANT Mrs. Pauline H. Schmidt Address 209 Leslie Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Ventricular Fibrillation DUE TO (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 20 min 30 min 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyper tension Cardiovascular Disease 30 yrs stand		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10:30 am 10-29, 1956 , to 11:30 am 10-29, 1956 , that I last saw the deceased alive on 11:55 am 10-29, 1956 , and that death occurred at 11:55 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Hyle		ADDRESS (Street, city or town, state) DATE SIGNED 7527 Belair Rd Baltimore Md 10308	
PHYSICIAN'S NAME (Type) JOHN C. Hyle M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 2, 1956	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR NOV - 1 1956	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Mrs. L. L. B. B. B.	

RECEIVED

NOV 1 1956

BUREAU V. S.

10102

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home-301 Chesapeake Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle AMELIA Last SCOTT				4. DATE OF DEATH Month Oct. Day 3, Year 19 56			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1880	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Wm. P. Backmiller				14. MOTHER'S MAIDEN NAME Mary Amelia Wasmus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Harry Scott - 108 Wyndhurst Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute infectious cardiovascular disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan. 3, 1956 to Oct. 3, 1956 , that I last saw the deceased alive on Sept. 30, 1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Allan Spier				ADDRESS (Street, city or town, state) 4408 Loch Raven Blvd Baltimore 18, Md			
PHYSICIAN'S NAME (Type) A. ALLAN SPIER				DATE SIGNED Oct 8 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORY Friends Burial Ground		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons - Balto. 17, Md.				24a. REC'D BY REGISTRAR DATE 8 1956		24b. REGISTRAR'S SIGNATURE Malcolm Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18100885

Item 4 Film 9205 10-10-56 et

10103

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's Co. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7mths3dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tall Timbers, Maryland		d. STREET ADDRESS Tall Timbers, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alexander I. Middle Sheehan Last Sheehan		4. DATE OF DEATH Month October Day 2 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.	IF UNDER 24 HRS. Months 7 Days 14 Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX Merchant		10b. KIND OF BUSINESS OR INDUSTRY Store	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME XXXXXX John Sheehan	
14. MOTHER'S MAIDEN NAME XXXXXX Ellen J. Bean		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c) 422.1			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 29 , 19 56 , to Oct. 2 , 19 56 , that I last saw the deceased alive on Oct. 2 , 19 56 , and that death occurred at 11:20p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		DATE SIGNED 10-3-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56	22c. NAME OF CEMETERY OR CREMATORY St. Georges
22d. LOCATION (City, town, or county) Valley Lee, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robinson Funeral Home Leonardtown		24a. REC'D BY REGISTRAR DATE 10/5/56	
24b. REGISTRAR'S SIGNATURE Glen P. Hauser		24c. REGISTRAR'S SIGNATURE Glen P. Hauser	

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1956 8 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10087

10104

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Id. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1421 Glendale Road				d. STREET ADDRESS 1421 Glendale Road			
3. NAME OF DECEASED (Type or print) First Otho Middle Thomas Last Shepherd				4. DATE OF DEATH Month October Day 22 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 12 Days 19 Hours 19 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME W. Sheperd				14. MOTHER'S MAIDEN NAME Helen Domer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rhoda J. Shannon Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Renal-Vascular Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 20 , 19 56 to Oct. 22 , 19 56 , that I last saw the deceased alive on Oct. 22 , 19 56 , and that death occurred at 5:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Shannon		M.D. 820 Medical Arts Building Balto. Md.		ADDRESS (Street, city or town, state) 820 Medical Arts Building Balto. Md.		DATE SIGNED	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/56		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or county) (State) Shepherdstown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home, Boonsboro, Maryland				24a. REC'D BY REGISTRAR DATE 10/26/56		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Ruffenrath	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, the registrar, and the informant, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 29 1956

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1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

10105 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		MARYLAND		STATE N.Y.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) COCKEYSVILLE		LENGTH OF STAY (in this place) 19 MONTHS		CITY (If outside corporate limits, write RURAL and give nearest town) GREEN		69X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MASONIC HOME				STREET ADDRESS (If rural give location) INDIAN BROOK RD			
3. NAME OF DECEASED (Type or Print) CATHERINE E SIDLEY				4. DATE OF DEATH (Month) OCT (Day) 18 (Year) 19 56			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 9/18/1862	9. AGE last birthday 94 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MICHAEL THORNE				14. MOTHER'S MAIDEN NAME ISABELL L. SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Frank L. Smith Jr. Cockeysville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) Arterio-Sclerotic Cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 15 months			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/6, 19 55, to 10/17, 19 56, that I last saw the deceased alive on 10/17, 19 56, and that death occurred at 12:10 A.M. from the causes and on the date stated above.							
SIGNATURE Walter J. Kues		M.D.		ADDRESS (Street, city, town, state) Cockeysville Md.		DATE SIGNED 10/18/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/20/56		NAME OF CEMETERY OR CREMATORY Lorraine		LOCATION (City, town, or county) Baltimore, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Frank Smith		25. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc - 1217 St Paul St		ADDRESS	

VS A15C 1-55 10M

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10106

CERTIFICATE OF DEATH

Reg. Dist. No. 10089 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 701 W. Joppa Rd.				d. STREET ADDRESS 701 W. Joppa Rd.			
3. NAME OF DECEASED (Type or print) First A. Middle CLARENCE Last SMINK				4. DATE OF DEATH Month Oct. Day 31 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1875		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Hebbville, Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rose Talley Smink, 701 W. Joppa Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) Infirmities of age							INTERVAL BETWEEN ONSET AND DEATH 5 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from 10/31 , 19 55 , to 10/31 , 19 56 , that I last saw the deceased alive on 10/31 , 19 56 , and that death occurred at 10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Thos G. Abbott M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Oct. 31, 1956			
PHYSICIAN'S NAME (Type) Thomas G. Abbott, M.D.				4509 Liberty Heights Ave. - Balto., Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/1956		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Heights Ave				24a. REC'D BY REGISTRAR 5 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 .10.107 CERTIFICATE OF DEATH

10090 38
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1804 Aberdeen Road</u>				d. STREET ADDRESS <u>1804 Aberdeen Road #4</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>SNYDER, SR.</u>				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/1879</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pinkerton Detective Agency Balto. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>Mr. John W. Snyder-1804 Aberdeen Road #4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular renal disease</u> DUE TO (c) <u>Hemiplegia</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General arterio-sclerosis - hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27, 19 56</u> to <u>Oct-12, 19 56</u> that I last saw the deceased alive on <u>Oct-12, 19 56</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Lee K Fargo</u> M.D.				ADDRESS (Street, city or town, state) <u>8155 Loch Raven Blvd</u> DATE SIGNED <u>Oct 12 1956</u>			
PHYSICIAN'S NAME (Type) <u>DR LEE K FARCO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. [illegible]</u> ADDRESS <u>Balto - 12 [illegible]</u>				24a. REC'D BY REGISTRAR <u>Oct 15 1956</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Mabel [illegible]</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10108

CERTIFICATE OF DEATH

10091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2205 Old Frederick Rd.				d. STREET ADDRESS 2205 Old Frederick Rd.			
3. NAME OF DECEASED (Type or print) First Mary Middle Bertha Last Springer				4. DATE OF DEATH Month Oct. Day 16. Year 19 56			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1889	9. AGE (In years last birthday) yrs. 67	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William I. Boswell				14. MOTHER'S MAIDEN NAME Nancy Riley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Eugene R. Springer, 2205 Old Frederick Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension - Essential (c) Hypertension - Essential							INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 15 yrs. 18 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis & Hypertension Heart Disease - Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore			
20h. (State) Md.							
21. I certify that I attended the deceased from January , 19 37 , to Oct. 16 , 19 56 , that I last saw the deceased alive on Oct 15 , 19 56 , and that death occurred at 5:00 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert J. Shochat				ADDRESS (Street, city or town, state) 4111 Liberty Heights Ave. Balt., Md.			
M.D. Albert J. Shochat M.D.				DATE SIGNED 10/16/56			
PHYSICIAN'S NAME (Type) Albert J. Shochat M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke				ADDRESS 4101 Edmondson Ave.		24a. RECD BY REGISTRAR 181956	
				24b. REGISTRAR'S SIGNATURE T. E. Barry			

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OCT 18 1956

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10109

CERTIFICATE OF DEATH

1009244
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 510 D ST.		d. STREET ADDRESS 510 D ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle SCOTT Last STEVENSON		4. DATE OF DEATH Month 10 Day 15 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 28, 1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFG.	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HUGH STEVENSON		14. MOTHER'S MAIDEN NAME MARY F. BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 713-04-2588A	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Hypostatic Pneumonia DUE TO (b) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis Ht. Disease		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 1 1/2 yrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 52 , to Oct. 15 , 19 56 , that I last saw the deceased alive on Oct. 15 , 19 56 , and that death occurred at 11:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. T. Means		ADDRESS (Street, city or town, state) 520 D ST. BALTO. MD.	
PHYSICIAN'S NAME (Type) J. T. Means		DATE SIGNED 10/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-18-56	22c. NAME OF CEMETERY OR CREMATORY ORCHARD HAVEN	22d. LOCATION (City, town, or county) (State) BALTO. CO., MD
23. FUNERAL DIRECTOR'S SIGNATURE Walter George Buckley, Remondale, Md.		24a. REC'D BY REGISTRAR DATE 10-18-1956	
24b. REGISTRAR'S SIGNATURE Harmon L. Farber			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. MARITAL STATUS [Faint text]		7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]		11. SIGNATURE OF REGISTRAR [Faint text]		12. SIGNATURE OF WITNESS [Faint text]		13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]		15. SIGNATURE OF OTHER [Faint text]		16. SIGNATURE OF OTHER [Faint text]		17. SIGNATURE OF OTHER [Faint text]		18. SIGNATURE OF OTHER [Faint text]		19. SIGNATURE OF OTHER [Faint text]		20. SIGNATURE OF OTHER [Faint text]		21. SIGNATURE OF OTHER [Faint text]		22. SIGNATURE OF OTHER [Faint text]		23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]		25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]		27. SIGNATURE OF OTHER [Faint text]		28. SIGNATURE OF OTHER [Faint text]		29. SIGNATURE OF OTHER [Faint text]		30. SIGNATURE OF OTHER [Faint text]		31. SIGNATURE OF OTHER [Faint text]		32. SIGNATURE OF OTHER [Faint text]		33. SIGNATURE OF OTHER [Faint text]		34. SIGNATURE OF OTHER [Faint text]		35. SIGNATURE OF OTHER [Faint text]		36. SIGNATURE OF OTHER [Faint text]		37. SIGNATURE OF OTHER [Faint text]		38. SIGNATURE OF OTHER [Faint text]		39. SIGNATURE OF OTHER [Faint text]		40. SIGNATURE OF OTHER [Faint text]		41. SIGNATURE OF OTHER [Faint text]		42. SIGNATURE OF OTHER [Faint text]		43. SIGNATURE OF OTHER [Faint text]		44. SIGNATURE OF OTHER [Faint text]		45. SIGNATURE OF OTHER [Faint text]		46. SIGNATURE OF OTHER [Faint text]		47. SIGNATURE OF OTHER [Faint text]		48. SIGNATURE OF OTHER [Faint text]		49. SIGNATURE OF OTHER [Faint text]		50. SIGNATURE OF OTHER [Faint text]		51. SIGNATURE OF OTHER [Faint text]		52. SIGNATURE OF OTHER [Faint text]		53. SIGNATURE OF OTHER [Faint text]		54. SIGNATURE OF OTHER [Faint text]		55. SIGNATURE OF OTHER [Faint text]		56. SIGNATURE OF OTHER [Faint text]		57. SIGNATURE OF OTHER [Faint text]		58. SIGNATURE OF OTHER [Faint text]		59. SIGNATURE OF OTHER [Faint text]		60. SIGNATURE OF OTHER [Faint text]		61. SIGNATURE OF OTHER [Faint text]		62. SIGNATURE OF OTHER [Faint text]		63. SIGNATURE OF OTHER [Faint text]		64. SIGNATURE OF OTHER [Faint text]		65. SIGNATURE OF OTHER [Faint text]		66. SIGNATURE OF OTHER [Faint text]		67. SIGNATURE OF OTHER [Faint text]		68. SIGNATURE OF OTHER [Faint text]		69. SIGNATURE OF OTHER [Faint text]		70. SIGNATURE OF OTHER [Faint text]		71. SIGNATURE OF OTHER [Faint text]		72. SIGNATURE OF OTHER [Faint text]		73. SIGNATURE OF OTHER [Faint text]		74. SIGNATURE OF OTHER [Faint text]		75. SIGNATURE OF OTHER [Faint text]		76. SIGNATURE OF OTHER [Faint text]		77. SIGNATURE OF OTHER [Faint text]		78. SIGNATURE OF OTHER [Faint text]		79. SIGNATURE OF OTHER [Faint text]		80. SIGNATURE OF OTHER [Faint text]		81. SIGNATURE OF OTHER [Faint text]		82. SIGNATURE OF OTHER [Faint text]		83. SIGNATURE OF OTHER [Faint text]		84. SIGNATURE OF OTHER [Faint text]		85. SIGNATURE OF OTHER [Faint text]		86. SIGNATURE OF OTHER [Faint text]		87. SIGNATURE OF OTHER [Faint text]		88. SIGNATURE OF OTHER [Faint text]		89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]		91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]		93. SIGNATURE OF OTHER [Faint text]		94. SIGNATURE OF OTHER [Faint text]		95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]		97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]		99. SIGNATURE OF OTHER [Faint text]		100. SIGNATURE OF OTHER [Faint text]	
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BUREAU V. B.

OCT 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10093

Reg. Dist. No.

43

10110

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Willow Ave.				d. STREET ADDRESS 5 Willow Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Laura Middle R. Last Steward				4. DATE OF DEATH Month October Day 30 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1885		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Westminster, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James C. Mobley				14. MOTHER'S MAIDEN NAME Myra Lykens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles W. Steward		Address 5 Willow Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 175x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Coronary (c) Primary Coronaries				INTERVAL BETWEEN ONSET AND DEATH 2 2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 , 19 56 , to Oct 30 , 19 56 , that I last saw the deceased alive on 10-29 , 19 56 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Michael J. Grossfeld				ADDRESS (Street, city or town, state) 5401 Belair Rd. Balt. Md.			
PHYSICIAN'S NAME (Type) M. J. GROSSFELD M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olive		22d. LOCATION (City, town, or county) (State) Randallstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Mrs. A. L. Reifer			

NOV 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10111

CERTIFICATE OF DEATH

10094

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 yrs. 4 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Catonsville Convalescent Home 315 Ingleside Avenue				d. STREET ADDRESS 703 Hillen Road			
3. NAME OF DECEASED (Type or print) Susanna Virginia Swam				4. DATE OF DEATH Month October Day 25 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1871	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 25 Days 19 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William Henry Swam				14. MOTHER'S MAIDEN NAME Clara Jane Painter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 422,1		17. INFORMANT Miss Bertha N. Swam Address Baltimore 17 151 W. Lafayette Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 422,1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) Epilepsy						INTERVAL BETWEEN ONSET AND DEATH 5 days 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept 21, 1954 to Oct. 25, 1956 , that I last saw the deceased alive on Oct. 24, 1956 , and that death occurred at 9 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joshua H. Armacost M.D.				ADDRESS (Street, city or town, state) 6419 Windsor Mill Road			
PHYSICIAN'S NAME (Type) JOSHUA H. ARMACOST				DATE SIGNED Baltimore 7 Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's (Hampden)		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Ronald F. Burgee				24a. REC'D BY REGISTRAR Oct. 29, 1956		24b. REGISTRAR'S SIGNATURE T. E. Harry	

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Classmate, Mr. [Name]

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BUREAU V. S.

OCT 30 1956

RECEIVED

may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10112 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10095 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>37 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>2702 Pelham Avenue</u>			
3. NAME OF DECEASED (Also: ROBERT LOUIS SWITZER) (Type or print)				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1895</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman - city- retired Fire Department</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Charles Sweitzer</u>			
14. MOTHER'S MAIDEN NAME <u>Rose Siefert</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>Yes WW I</u>			
16. SOCIAL SECURITY NO. <u>217-26-6847</u>				17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>411X</u> DUE TO <u>RHEUMATIC HEART DISEASE WITH AORTIC STENOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>VA</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VA</u>	
20f. (City or town) (County) (State) <u>Baltimore, Maryland</u>							
21. I certify that I attended the deceased from <u>August 28, 1956</u> , to <u>October 4, 1956</u> , and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James H. Nolan, M.D.</u> <u>10/4/56</u>							
ACTUAL SIGNATURE <u>James H. Nolan</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u>							
PHYSICIAN'S NAME (Type) <u>JAMES H. NOLAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-8-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>				24a. REC'D. BY REGISTRAR <u>10/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farber</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		MORBID CAUSE		PERMANENT CAUSE		MORBID CAUSE		PERMANENT CAUSE		MORBID CAUSE		PERMANENT CAUSE	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES	

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10113

CERTIFICATE OF DEATH

10096

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lane</u> <u>Caton Ridge Nursing Home-329 Harlem</u>		d. STREET ADDRESS <u>1825 E. 31st St.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last <u>TALL</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>11</u> , Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1866</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (rtd)</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	9c. AGE (In years lost birthday) yrs. <u>90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	10c. PLACE OF BIRTH (State or foreign country) <u>Md.</u>
11. CITIZEN OF WHAT COUNTRY? <u>--</u>		12. CITIZEN OF WHAT COUNTRY? <u>--</u>	
13. FATHER'S NAME <u>John H. Riehl</u>		14. MOTHER'S MAIDEN NAME <u>Catherine H. --</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Mr. J. H. Riehl, Jr.</u>		Address <u>4439 Wickford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>--</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>yo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 11</u> , 19 <u>56</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest C Brown</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1101 N Calvert St, Balt. 2 10/13/56</u>	
PHYSICIAN'S NAME (Type) <u>Ernest C Brown</u>		<u>1101 N. Calvert St BALT, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>161956</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Lany</u>		24c. DATE <u>10/13/56</u>	

OCT 17 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG205 10-29-56 et

10114

CERTIFICATE OF DEATH

Reg. Dist. No.

10097 45

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Middle River</i>				c. LENGTH OF STAY IN 1b <i>40 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle <i>EMMA</i> Last <i>VA. TAYLOR</i>				4. DATE OF DEATH Month <i>October</i> Day <i>20,</i> Year <i>19 56</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21, 1890</i>	9. AGE (In years last birthday) <i>66</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dom-Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Mengel</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Albert Taylor</i> Address <i>Towson 4 Md. 501 Overbrook Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Sclerosis</i> DUE TO (c) <i>1 hour</i> <i>10 years</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>April 19, 1946</i> to <i>Oct 20, 1956</i> , that I last saw the deceased alive on <i>Oct 20, 1956</i> , and that death occurred at <i>730 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. H. Kolodny</i>		M.D. <i>1225 Eastern Blvd</i>		DATE SIGNED <i>10/20/56</i>			
PHYSICIAN'S NAME (Type) <i>Balt. 21, 1956</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-24-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Landon Pk.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly</i>		ADDRESS <i>Essex Md.</i>		24a. REC'D BY REGISTRAR <i>OCT 24 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>	

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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10115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1218 Boyce ave</u>				d. STREET ADDRESS <u>1218 Boyce ave</u>			
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>MAY</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Warren, Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Spilker - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> 4201 DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 12, 1956</u> , to <u>OCT 14, 1956</u> , that I last saw the deceased alive on <u>OCT 11, 1956</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thaddeus C. Swinski</u>				ADDRESS (Street, city or town, state) <u>17 W. PENNA. AVE. TOWSON 4 MD</u>			
PHYSICIAN'S NAME (Type) <u>THADDEUS C. SWINSKI</u>				DATE SIGNED <u>OCT 15, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>OCT 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co</u>				ADDRESS <u>4905 York Road</u>		24a. REC'D BY REGISTRAR <u>Oct. 17, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10116

CERTIFICATE OF DEATH

10099
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 1007 Sharp Street			
3. NAME OF DECEASED (Type or print) First Middle Last AARON E THOMAS				4. DATE OF DEATH Month Day Year October 9 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/90	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Aaron Thomas		14. MOTHER'S MAIDEN NAME Cassie (Maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 212-05-5122		17. INFORMANT Address Clin Rec. Vets. Admin. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 177x (c) 177x DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. g. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 2, 19 56 , to October 9, 19 56 , that I saw the deceased alive on October 9, 19 56 , and that death occurred at 1:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark				M.D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED 10/10/56	
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Law				ADDRESS Charles E. Law, 102 Ch. Madison Ave., Balto.		24a. REC'D BY REGISTRAR 151956	
24b. REGISTRAR'S SIGNATURE Lawson L. Lark							

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

10117 10100 44 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 77 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLIS Middle THOMAS Last THOMAS				4. DATE OF DEATH Month October Day 2 Year 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1895	
9. AGE (In years last birthday) yrs. 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		11. BIRTHPLACE (State or foreign country) Prince Edward Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-07-1093		17. INFORMANT Address Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LEFT MAXILLARY SINUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LOBULAR PNEUMONIA DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 17, 1956 to October 2, 1956 and that death occurred at 5:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.				DATE SIGNED 10/3/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray O. Wilson				24a. REC'D BY REGISTRAR 15 1956			
ADDRESS 1000 Brantley Ave., Balto., Md.				24b. REGISTRAR'S SIGNATURE L. L. L...			

RECEIVED

OCT 5 1956

BUREAU A

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. The Registrar shall be notified by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 10101 30 282										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's Co.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN lb 18yrs10mth		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Mary's Co. 18x-2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS Park Hall - St. Mary's Co.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Addie Middle R. Last Tippett					4. DATE OF DEATH Month 10 Day 29 Year 1956					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1884		9. AGE (In years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 904.7 DUE TO Arteriosclerotic cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple decubitus DUE TO Fracture right hip. Accident (c) Pneumonia								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell to floor on July 13, 1956 sustaining a fracture of the right hip.							
20c. TIME OF INJURY Month, Day, Year Hour 4:30 a. m. 7-13-56 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE George M. Kieffer					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) George M. Kieffer, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED					
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial			22b. DATE THEREOF 11/1/56		22c. NAME OF CEMETERY OR CREMATORY Trinity			22d. LOCATION (City, town, or county) (State) St. Mary's Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W. Blake Mattingly					ADDRESS Londontown, Md.		24a. REC'D BY REGISTRAR 10/31/56		24b. REGISTRAR'S SIGNATURE W. Blake Mattingly	

MEDICAL EXAMINERS CERTIFICATE OF DEATH

BUREAU V. 8

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10102

Reg. Dist. No. 41

9978

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 2927 Yorkway Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benny Middle Abedine Last Turani Jr.				4. DATE OF DEATH Month October Day 10 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 21, 1956	
9. AGE (In years last birthday) yrs. 3 1/2		IF UNDER 1 YEAR Months 3 1/2 Days 3		IF UNDER 24 HRS. Hours 3 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) STUEBENVILLE, OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benny Abedine Turani Sr.				14. MOTHER'S MAIDEN NAME Marilyn Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT BENNY A. TURANI SR. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Vomitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 921.0 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vomited and aspirated.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10/10 19 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Dundalk (County) Balto. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/10/56	
EXAMINER'S NAME (Type) William V. Lovitt, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-12-56		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) BALTIMORE CO. (State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Burke Proddy</i> ADDRESS Dundalk, Md				24a. REC'D BY REGISTRAR DATE Oct 15 1956		24b. REGISTRAR'S SIGNATURE <i>Tom Kelly</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CITY AND COUNTY [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		SIGNATURE OF MEDICAL EXAMINER [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		DATE OF REGISTRATION [Illegible]	

RECEIVED
 OCT 16 1956
 BUREAU V. S.

Original and copy sent to [Illegible]

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10119
CERTIFICATE OF DEATH

10103
Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 16 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood Lane		d. STREET ADDRESS Rosewood Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edna Middle M. Last Turnbaugh		4. DATE OF DEATH Month Oct Day 6 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Morris		14. MOTHER'S MAIDEN NAME Eli Lytle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-09-7406	
17. INFORMANT William F. Turnbaugh, Owings Mills, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 1953 , to Oct 6 , 1956 , that I last saw the deceased alive on 6 Oct , 1956 , and that death occurred at 7:10 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pikesville 8 Md DATE SIGNED 6 Oct 56 ACTUAL SIGNATURE Paul H Royse M.D. PHYSICIAN'S NAME (Type) PAUL H ROYSE MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct, 8, 56	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 10-6-56	
24b. REGISTRAR'S SIGNATURE Mary B. Eline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10104 38

Reg. Dist. No.

10120

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1813 N. Mount Street			
3. NAME OF DECEASED (Type or print) First Middle Last CLAUDE DONALD URQUHART				4. DATE OF DEATH Month Day Year October 24 19 56			
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1902		9. AGE (In years last birthday) 54 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Consolidated Cold Storage		11. BIRTHPLACE (State or foreign country) Phoebe, Va.			
13. FATHER'S NAME John Urquhart				14. MOTHER'S MAIDEN NAME Alice Cross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-0358		17. INFORMANT Address Mrs. Gertrude Urquhart - 1813 N. Mount Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D. EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				DATE SIGNED 10/25/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/56		22c. NAME OF CEMETERY OR CREMATORY Greenwood			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles R. Law 802 Madison Avenue				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 20 1956 <i>Mabel Gray</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. The funeral director should be notified by the registrar of the burial, cremation, or removal.

BUREAU V. S.

OCT 29 1956

RECEIVED

10121

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fert Howard				c. LENGTH OF STAY IN 1b 11 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Box 202			
3. NAME OF DECEASED (Type or print) First JACOB Middle G. Last WAGNER				4. DATE OF DEATH Month October Day 12 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/7/92	
9. AGE (In years last birthday) 63 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY MASON		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jerry Wagner			
14. MOTHER'S MAIDEN NAME Elizabeth Gimmel				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I			
16. SOCIAL SECURITY NO. 212-28-4359				17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA DIFFUSE MULTIPLE PULMONARY ABSCESSSES DUE TO 521X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 1, 1956 to October 12, 1956 and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE C.J. Papastrat MD				M.D. _____			
PHYSICIAN'S NAME (Type) C.J. PAPASTRAT, M.D.				VAH, Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/56		22c. NAME OF CEMETERY OR CREMATORY Edwards Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS Funeral Home Duke of Gloucester St.		24a. REC'D BY REGISTRAR 15 1956	
24b. REGISTRAR'S SIGNATURE Dawson L. Taylor							

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of informant		14. Address of informant		15. Telephone number	
16. Name of funeral home		17. Address of funeral home		18. Telephone number	
19. Name of cemetery		20. Address of cemetery		21. Telephone number	
22. Name of undertaker		23. Address of undertaker		24. Telephone number	
25. Name of physician		26. Address of physician		27. Telephone number	
28. Name of hospital		29. Address of hospital		30. Telephone number	
31. Name of nursing home		32. Address of nursing home		33. Telephone number	
34. Name of hospice		35. Address of hospice		36. Telephone number	
37. Name of funeral home		38. Address of funeral home		39. Telephone number	
40. Name of cemetery		41. Address of cemetery		42. Telephone number	
43. Name of undertaker		44. Address of undertaker		45. Telephone number	
46. Name of physician		47. Address of physician		48. Telephone number	
49. Name of hospital		50. Address of hospital		51. Telephone number	
52. Name of nursing home		53. Address of nursing home		54. Telephone number	
55. Name of hospice		56. Address of hospice		57. Telephone number	
58. Name of funeral home		59. Address of funeral home		60. Telephone number	
61. Name of cemetery		62. Address of cemetery		63. Telephone number	
64. Name of undertaker		65. Address of undertaker		66. Telephone number	
67. Name of physician		68. Address of physician		69. Telephone number	
70. Name of hospital		71. Address of hospital		72. Telephone number	
73. Name of nursing home		74. Address of nursing home		75. Telephone number	
76. Name of hospice		77. Address of hospice		78. Telephone number	
79. Name of funeral home		80. Address of funeral home		81. Telephone number	
82. Name of cemetery		83. Address of cemetery		84. Telephone number	
85. Name of undertaker		86. Address of undertaker		87. Telephone number	
88. Name of physician		89. Address of physician		90. Telephone number	
91. Name of hospital		92. Address of hospital		93. Telephone number	
94. Name of nursing home		95. Address of nursing home		96. Telephone number	
97. Name of hospice		98. Address of hospice		99. Telephone number	
100. Name of funeral home		101. Address of funeral home		102. Telephone number	

BUREAU V. S.

OCT 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please return carbon papers, pages 1 and 2, to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9979

CERTIFICATE OF DEATH

10106 4/1

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>17 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u> 53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 DUNDALK AVE</u>				d. STREET ADDRESS <u>65 DUNDALK AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET MULLER WAGNER</u>			4. DATE OF DEATH Month Day Year <u>10-24-1956</u>				
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 15, 1867</u>	
9. AGE (In years lost birth day) <u>89</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>(?) MULLER</u>			
14. MOTHER'S MAIDEN NAME <u>UNK.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>HENRY W. WAGNER</u> Address <u>SAME ADDRESS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-22</u> , 19 <u>56</u> , to <u>10-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>56</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack C Collins</u>				ADDRESS (Street, city or town, state) <u>2 Kinskys Balt 22</u>			
PHYSICIAN'S NAME (Type) <u>JACK C Collins</u>				DATE SIGNED <u>10-26-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Colth David Bradley, Dundalk, MD</u>				24a. REC'D BY REGISTRAR <u>ACT 30 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Lasker</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3

OCT 30 1956

RECEIVED

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
OCCUPATION		MARRIAGE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL RECORD	
FAMILY HISTORY		SOCIAL HISTORY		PSYCHOLOGICAL HISTORY	
PATHOLOGICAL FINDINGS		LABORATORY TESTS		RADIOLOGICAL FINDINGS	
TREATMENT		PROGNOSIS		FOLLOW-UP	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10122 CERTIFICATE OF DEATH

10107 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWLEYS QUARTERS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Clarks Pt. Rd. Box 52</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>G.</u> Last <u>Heibel</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28 - 1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Battery Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Heibel</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Killian M. Stinchcomb</u>		Address <u>Grove</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>541.0</u> DUE TO <u>GASTRIC HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Peptic Ulcer</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>3 Mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA LARYNX</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 1956, to <u>Oct 23</u> , 1956, that I last saw the deceased alive on <u>Oct 22</u> , 1956, and that death occurred at <u>5 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Semenovoff</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1437 Funlay Ave. 10/25/56</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>		<u>Balto 20, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 26 - 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Ave. Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>Essex, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Larson & Farber</u>	

CERTIFICATE OF DEATH

0183

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF REGISTRAR [Faint text]		12. DATE [Faint text]	

BUREAU V. S.

OCT 20 1956

RECEIVED

10123 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. NAME OF DECEASED
(Type or Print)

Michael L. Weaver

2. DATE
OF
DEATH

Oct. 5, 1956

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore County

4. USUAL RESIDENCE (Where deceased lived, if institution; residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

90 House in the Pine Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

3101-4

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2405 East Federal Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Nov. 6, 1894

9. AGE (In years
last birthday)

61 yrs.

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR
INDUSTRY

Globe Detective Agency

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William E. Weaver

14. MOTHER'S MAIDEN NAME

Mary L. Pugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-12-0486

17. INFORMANT

Florence C. Daniels

ADDRESS

2405 E. Federal St.

18.

163X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinoma of lung & myeloid leukemia

INTERVAL BETWEEN
ONSET AND DEATH

unknown

ANTECEDENT CAUSES

(B)
(C)DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN
PART OF DEATH

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from 30 June 55 to 19 Sept 56, that (I) (we) last saw the deceased alive on 19 Sept 56, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

[Signature]

23B. ADDRESS

1513 N. Milford Ave

23C. DATE SIGNED

5 Oct 56

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 8 1956

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

October 6, 1956

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

John E. Miller Inc - 2431 E. Olive St.

ADDRESS

2431 E. Olive St.

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

M. CERTIFICATION

RECEIVED

OCT 9 1956

BUREAU W. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10124

CERTIFICATE OF DEATH

10109

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5mths 6 dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2310 East Chase Street - Balto.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Weinberg Last Weinberg		4. DATE OF DEATH Month October Day 24 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 68? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6, 19 56 , to Oct. 24, 19 56 , that I last saw the deceased alive on Oct. 24, 19 56 , and that death occurred at 9:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachster M.D. SPRING GROVE STATE HOSPITAL 10-24-56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Stella Wachster, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-25-1956	22c. NAME OF CEMETERY OR CREMATORY Windsor Hill Def	22d. LOCATION (City, town, or county) (State) Balto Md.
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc		ADDRESS Balto Md 2100 Eastern Pl.	24a. REC'D BY REGISTRAR DATE 10/26/56
24b. REGISTRAR'S SIGNATURE Victor C. Harry			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1890	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915	
9. NAME OF SPOUSE Mary E. Harris		10. DATE OF DEATH 1956	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction	
15. PHYSICIAN'S SIGNATURE Dr. J. H. Smith		16. PLACE OF INTERMENT Catholic Cemetery	
17. NAME OF FUNERAL HOME John Doe & Co.		18. SIGNATURE OF FUNERAL HOME John Doe	
19. NAME OF WITNESS John Doe		20. SIGNATURE OF WITNESS John Doe	
21. NAME OF REGISTRAR John Doe		22. SIGNATURE OF REGISTRAR John Doe	

BUREAU V. 2

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10125 CERTIFICATE OF DEATH

Reg. Dist. No. 30

10110

1. PLACE OF DEATH: COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>AA.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LOTHIAN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in The Pines</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Edith</u>	<u>Shepherd</u>	<u>Welch</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>10-19-70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>LOTHIAN, MD.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>OWEN SHEPHERD</u>		14. MOTHER'S MAIDEN NAME <u>KATE HILDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>1</u>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>McLEAN Welch, Annapolis, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

4204 Immediate cause (a) Coronary Thrombosis 1 da.

Antecedent cause(s) (b) Hypertensive Cardio-Vascular Disease 10-yr. (?)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/20, 1952, to 10-19, 1956, that I last saw the deceased alive on 10-18, 1956, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>10/21/56</u>	NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>	LOCATION (City, town, or county) <u>LOTHIAN, MD.</u>
DATE REC'D BY LOCAL REG. <u>10/29/56</u>	REGISTRAR'S SIGNATURE <u>T.E. Harvey</u>	24. FUNERAL DIRECTOR <u>B.L. Hopping & SON, Annapolis, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A

BUREAU V. S.

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

101112

10126

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brick Walk Stone Chapel La.</u>		d. STREET ADDRESS <u>Brick Walk Stone Chapel La</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH WHARTON</u>		4. DATE OF DEATH <u>Oct 19</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phila Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W Wharton</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Page</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Wm. A Howard</u>		Address <u>Pikesville md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio sclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u> <u>15 yrs.</u> <u>25 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 39</u> to <u>Oct 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 19</u> , 19 <u>56</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Pikesville 8, Md</u> DATE SIGNED <u>Oct 21 56</u>	
ACTUAL SIGNATURE <u>Palmer FC Williams</u> M.D.		DATE SIGNED <u>Oct 21 56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Oct 22 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory W. Jenkins Sons Co</u> ADDRESS <u>4905 York Rd</u>		24. REC'D BY REGISTRAR <u>Oct 23 1956</u> REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF CORONER		20. SIGNATURE OF DISTRICT ATTORNEY		21. SIGNATURE OF COUNTY CLERK	
22. SIGNATURE OF STATE CLERK		23. SIGNATURE OF SECRETARY OF HEALTH		24. SIGNATURE OF COMMISSIONER OF HEALTH	
25. SIGNATURE OF GOVERNOR		26. SIGNATURE OF PRESIDENT		27. SIGNATURE OF VICE PRESIDENT	
28. SIGNATURE OF SENATE		29. SIGNATURE OF HOUSE OF REPRESENTATIVES		30. SIGNATURE OF SUPREME COURT	
31. SIGNATURE OF JUSTICE		32. SIGNATURE OF CHIEF JUSTICE		33. SIGNATURE OF CLERK OF SUPREME COURT	
34. SIGNATURE OF CLERK OF HOUSE		35. SIGNATURE OF CLERK OF SENATE		36. SIGNATURE OF CLERK OF DISTRICT COURT	
37. SIGNATURE OF CLERK OF COUNTY COURT		38. SIGNATURE OF CLERK OF JUDICIAL CIRCUIT		39. SIGNATURE OF CLERK OF APPELLATE COURT	
40. SIGNATURE OF CLERK OF SUPREME COURT		41. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		42. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
43. SIGNATURE OF CLERK OF SUPREME COURT		44. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		45. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
46. SIGNATURE OF CLERK OF SUPREME COURT		47. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		48. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
49. SIGNATURE OF CLERK OF SUPREME COURT		50. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		51. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
52. SIGNATURE OF CLERK OF SUPREME COURT		53. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		54. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
55. SIGNATURE OF CLERK OF SUPREME COURT		56. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		57. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
58. SIGNATURE OF CLERK OF SUPREME COURT		59. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		60. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
61. SIGNATURE OF CLERK OF SUPREME COURT		62. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		63. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
64. SIGNATURE OF CLERK OF SUPREME COURT		65. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		66. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
67. SIGNATURE OF CLERK OF SUPREME COURT		68. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		69. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
70. SIGNATURE OF CLERK OF SUPREME COURT		71. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		72. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
73. SIGNATURE OF CLERK OF SUPREME COURT		74. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		75. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
76. SIGNATURE OF CLERK OF SUPREME COURT		77. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		78. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
79. SIGNATURE OF CLERK OF SUPREME COURT		80. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		81. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
82. SIGNATURE OF CLERK OF SUPREME COURT		83. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		84. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
85. SIGNATURE OF CLERK OF SUPREME COURT		86. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		87. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
88. SIGNATURE OF CLERK OF SUPREME COURT		89. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		90. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
91. SIGNATURE OF CLERK OF SUPREME COURT		92. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		93. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
94. SIGNATURE OF CLERK OF SUPREME COURT		95. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		96. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
97. SIGNATURE OF CLERK OF SUPREME COURT		98. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		99. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
100. SIGNATURE OF CLERK OF SUPREME COURT		101. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		102. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	

BUREAU V. S.

OCT 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10112

10127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 8 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING G ROVE STATE HOSPITAL		d. STREET ADDRESS 4904 Alston Drive 2817 BRIGHTON STREET	
3. NAME OF DECEASED (Type or print) GEORGE First W Middle WHITESIDE Last		4. DATE OF DEATH OCTOBER 12, 1956 Month 12 Day 19 Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 23, 1866
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER (rtd)		10b. KIND OF BUSINESS OR INDUSTRY BAPTIST CHURCH	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WHITESIDE		14. MOTHER'S MAIDEN NAME ELIZA MAHOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT CHART SPRING GROVE STATE HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO Senility (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 9, 1956 , to OCT. 14, 1956 that I last saw the deceased alive on OCT. 14, 1956 , and that death occurred at 12.00 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Ward M.D.		ADDRESS (Street, city or town, state) Balto., Md. DATE SIGNED 10/15/56	
PHYSICIAN'S NAME (Type) Charles Ward M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/56	
22c. NAME OF CEMETERY OR CREMATORY Louison Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Am. J. Tidner & Sons ADDRESS Balto 17 Md		24a. REC'D BY REGISTRAR DATE OCT 15 1956 24b. REGISTRAR'S SIGNATURE V. E. Harry	

PLAYING

OCT 15 1956

RECEIVED

10128

CERTIFICATE OF DEATH

10113

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverville</u> c. LENGTH OF STAY IN 1b <u>28</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u> d. STREET ADDRESS <u>701. Chesapeake Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>THOMAS</u> Last <u>WIGGINS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 8 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired naval officer</u>	11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1900-1919</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Isabelle B. Wiggins</u> Address <u>Mellington Tenn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. ft.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>54</u> , to <u>10/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/26</u> , 19 <u>56</u> , and that death occurred at <u>7:05 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rena Becker</u>		ADDRESS (Street, city or town, state) <u>Spring Grove Hospital Catonsville</u> DATE SIGNED <u>10/27/56</u>	
PHYSICIAN'S NAME (Type) _____		M.D. <u>W.H.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct. 31-1956</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor</u> ADDRESS <u>Box Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>J. B. Taylor</u> DATE <u>11/29/56</u>	
		24b. REGISTRAR'S SIGNATURE _____	

RECEIVED

10129

CERTIFICATE OF DEATH

10114

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Waldorf, Maryland. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.		c. LENGTH OF STAY IN 1b 2 1/2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf 088-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		d. STREET ADDRESS Route #1 - Box 111		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Edward		First James Edward		Middle Williams	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/15/39		9. AGE (In years last birthday) 17		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) patient in hospital		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl E. Williams		14. MOTHER'S MAIDEN NAME Melda Ruth Mannis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (inspired multiple food particles in bronchus). DUE TO (b) Epilepsy - grand mal type DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden Since 2 yrs. of age.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1956 , to October 10, 1956 , that I last saw the deceased alive on October 10, 1956 , and that death occurred at 12:45 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Harry G. Butler		M.D. Owings Mills, Maryland		DATE SIGNED 10/11/56	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Owings Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEM.	
22d. LOCATION (City, town, or county) (State) Rockville, MD		23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Dunphy		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 10-16-56		24b. REGISTRAR'S SIGNATURE Mary E. Elie			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
RESIDENCE OF DECEASED		PLACE OF DEATH	
CITY OF DEATH		COUNTY OF DEATH	
STATE OF DEATH		MANNER OF DEATH	
CAUSE OF DEATH		MEDICAL ATTENDANT	
DATE OF BURIAL		PLACE OF BURIAL	
CITY OF BURIAL		COUNTY OF BURIAL	
STATE OF BURIAL		MANNER OF BURIAL	
CAUSE OF BURIAL		MEDICAL ATTENDANT	
DATE OF INTERMENT		PLACE OF INTERMENT	
CITY OF INTERMENT		COUNTY OF INTERMENT	
STATE OF INTERMENT		MANNER OF INTERMENT	
CAUSE OF INTERMENT		MEDICAL ATTENDANT	
DATE OF CREMATION		PLACE OF CREMATION	
CITY OF CREMATION		COUNTY OF CREMATION	
STATE OF CREMATION		MANNER OF CREMATION	
CAUSE OF CREMATION		MEDICAL ATTENDANT	

BUREAU V. 2

OCT 16 1956

RECEIVED

9980

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK - 22</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1912 QUEENSWAY</u>				d. STREET ADDRESS <u>1912 QUEENSWAY</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LOUISA</u> First <u>WILSON</u> Last				4. DATE OF DEATH <u>OCT</u> Month <u>25</u> Day <u>1956</u> Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 18, 1869</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REMER JACOB REMERS</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE GERMRAUTH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ROSALIE McNALLY 1912 QUEENSWAY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>432.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerotic Cardiovascular Disease</u> DUE TO (c) <u>Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 19, 1956</u> to <u>Oct 25, 1956</u> , that I last saw the deceased alive on <u>Oct 24, 1956</u> , and that death occurred at <u>11:05 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.				ADDRESS (Street, city or town, state) <u>Dundalk - 22 - Md</u> DATE SIGNED <u>6:00 morning + m Nov - 10/26/56</u>			
PHYSICIAN'S NAME (Type) <u>M.B. DAVIS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CITY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Reber</u> ADDRESS <u>401 S. Chester St.</u>				24a. REC'D BY REGISTRAR DATE <u>10/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person in charge of the funeral, should be filled with the information on pages 1 and 2. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10130 8,12 Film 205 10-16-56 et
CERTIFICATE OF DEATH

10116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST POINT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST POINT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7410 Belmant ave</u>		d. STREET ADDRESS <u>7410 Belmant ave</u>	
3. NAME OF DECEASED (Type or print) <u>Maryanna</u> First <u>Wisniewski</u> Middle <u>W</u> Last		4. DATE OF DEATH <u>October 12</u> 19 <u>56</u> Month <u>12</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2 1881</u> 1885
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handwrite</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handwrite</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Balcerak</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-1818</u>	
17. INFORMANT <u>Floyd Wisniewski</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Hypertension</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>6 years</u> <u>4 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>55</u> , to <u>Oct 12</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 12</u> 19 <u>56</u> , and that death occurred at <u>6:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>		ADDRESS (Street, city or town, state) <u>1010 North Point Rd Baltimore Md</u>	
DATE SIGNED <u>10/13/56</u>		M.D. <u>1010 North Point Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS A. Jacobs</u>		DATE <u>10/13/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>		22d. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD. DUNDALK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Weber</u>		ADDRESS <u>4015 Chester St</u>	
24a. REC'D BY REGISTRAR <u>15 1956</u>		24b. REGISTRAR'S SIGNATURE <u>James L. Fickling</u>	

The
 PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
 Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and let
 THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

10131

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10117

Baltimore Co. **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <u>WASHINGTON WORRELL WOOLSON Jr.</u>			2. DATE OF DEATH <u>10/11/56</u>		
3. PLACE OF DEATH: <u>Baltimore County</u> A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		
5. FULL NAME OF (If not in hospital or institution, give street address or location) <u>AT HOME</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE 45</u>		
c. Length of stay in Baltimore <u>25 yrs</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>1811 ABERDEEN RD</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>FEB 28 1885</u>		9. AGE (in years last birthday) <u>71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA PA.</u>
13. FATHER'S NAME <u>WASHINGTON WORRELL WOOLSON Sr.</u>			14. MOTHER'S MAIDEN NAME <u>MARY BETTS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>WIFE</u>

18. <u>420.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC HEART DISEASE - CONGESTIVE HEART FAILURE</u>	CAUSE OF DEATH (A) <u>ARTERIOSCLEROTIC HEART DISEASE - CONGESTIVE HEART FAILURE</u> (B) <u>HEART FAILURE</u> (C) <u>GENERALIZED ARTERIOSCLEROSIS</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>OCT 1</u> 19 <u>56</u> to <u>OCT 11</u> 19 <u>56</u> , that (I) (we) last saw the deceased alive on <u>OCT 10</u> 19 <u>56</u> , and that death occurred at <u>2:00A</u> m., from the causes and on the date stated above.				
23A. SIGNATURE <u>Donald W. Mintz</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23B. ADDRESS <u>3009 EVERGREEN AVE</u>	23C. DATE SIGNED <u>10/11/56</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/15/56</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Glennwood Mem garden</u>	24D. LOCATION (City, town, or county) (State) <u>Phila - Penna</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>10/12/56</u>	REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>	25. FUNERAL DIRECTOR ADDRESS <u>Leonard L. Luck 5305 Hartford</u>		

10132

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10118

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 6310 Frederick Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6310 Frederick Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Oliver Last Zimmerman				4. DATE OF DEATH Month October Day 31 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 29, 1891	
9. AGE (In years and months) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Man		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA USA	
13. FATHER'S NAME Joseph Zimmerman				14. MOTHER'S MAIDEN NAME Sophie (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-10-1200		17. INFORMANT Address Mrs. Gertrude M. Zimmerman. 6310 Frederick Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Oct. 31, 56	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-3-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Western Cem		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lichtenberg & Sons				ADDRESS Balto 17th St.		24a. REC'D BY REGISTRAR DATE Nov. 5, 1956	
				24b. REGISTRAR'S SIGNATURE F. E. Henry			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

